Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Oregon** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
ICF/MR Support Services Waiver

C. Waiver Number: OR.0375
Original Base Waiver Number: OR.0375.

D. Amendment Number: OR.0375.R02.03

E. Proposed Effective Date: *(mm/dd/yy)*
12/01/10

Approved Effective Date: 06/24/11
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
~ Update definitions of Abuse and Serious Events.
~ Update process for services and plan monitoring.
~ Update frequency of Support Services Brokerage certification.
~ Remove specific OAR citations.
~ Update complaint review process to include Management Reviews.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☐ **Appendix B – Participant Access and Eligibility**	

Component of the Approved Waiver	Subsection(s)
☑ Appendix C – Participant Services	C-1/C-3
☑ Appendix D – Participant Centered Service Planning and Delivery	D-1, D-2
☐ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	F-3
☑ Appendix G – Participant Safeguards	G-1
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
~ Update definitions of Abuse and Serious Events.
~ Update process for services and plan monitoring.
~ Update frequency of Support Services Brokerage certification.
~ Remove specific OAR citations.
~ Update complaint review process to include Management Reviews.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Oregon** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
ICF/MR Support Services Waiver

C. Type of Request: amendment

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: OR.0375
Waiver Number: OR.0375.R02.03
Draft ID: OR.06.02.06

D. Type of Waiver *(select only one):*

Regular Waiver

E.

Proposed Effective Date of Waiver being Amended: 07/01/09
Approved Effective Date of Waiver being Amended: 07/01/09

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☑ **A program authorized under §1115 of the Act.**

Specify the program:
The Oregon Health Plan.

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
To obtain support services, individuals are first enrolled in a Support Services Brokerage. The primary job of a Support Service Brokerage is to help an individual plan, arrange, and monitor supports needed to stay at home and use the community. Support Service Brokerages are governed and certified by standards outlined in state administrative rules. These rules also describe the seven key functions brokerages are to perform. Support Service Brokerages are assigned specific geographic areas in the state and a maximum number of people each will serve.

A major goal of Brokerage Support Services is to give an individual and their designated representative as much choice and control as possible within state and federal program guidelines. This choice and control is exercised in such key areas as plan development, use of available financial resources, and the selection and monitoring of service providers.

Objectives: This waiver will serve adults, aged 18 and older, who meet the ICF/MR level of care.
Brokerage Support Services are self-directed in-home or other personal supports that assist an individual to live in their own home or with family or friends and to fully participate in community life, including work, while addressing health and safety needs. Support services are based upon people having choice and control over life goals and services. Each individual will receive an individual plan and will be able to select and monitor the providers of desired services.

Brokerage organizations employ staff (Personal Agents) who help enrolled individuals develop an individual support plan, access available resources necessary to implement the plan, select people or organizations to provide specific support services, and monitor and evaluate the outcomes of delivered services.

Each Brokerage is required to have a Policy Oversight Group, responsible for guiding the organization. The membership of the group is at least 50% self advocates and family members.

Access is through local County Developmental Disability Programs (CDDP). Service Coordinators in these programs determine eligibility for support services and make referrals to the Brokerage.

Brokerage Support Services are in-home or other personal supports that assist an individual to live in their own home or with family or friends and to fully participate in community life, including work. Support services are based upon people having choice and control over life goals and services. Each individual will receive an individual plan and will be able to select and monitor the providers of needed and desired services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (•) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (•) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (•) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed

in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Staley Implementation Group oversees the implementation of support service. This broad-based stakeholder group reviews key implementation plans and policies, discusses issues related to support services, and reviews service data and quality assurance information. Information on the membership of the Staley Implementation Group and minutes of meetings can be accessed at the Arc of Oregon Web site.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Hartwig

First Name: DeAnna

Title: Administrator, Office of Federal Reporting and Financial Eligibility

Agency: Department of Human Services, Seniors and People with Disabilities

Address: 500 Summer St. NE, E-12

Address 2:

City: Salem

State: **Oregon**

Zip: 97301

Phone: (503) 947-1180 **Ext:** ☐ **TTY**

Fax: (503) 373-7002

E-mail: deanna.j.hartwig@state.or.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Oregon**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Erinn Kelley-Siel

State Medicaid Director or Designee

Submission Date: Jun 1, 2011

Last Name: Kelley-Siel

First Name: Erinn

Title: Acting Director

Agency: Department of Human Services

Address: 500 Summer St. NE,

Address 2:

City: Salem

State: **Oregon**

Zip: 97301

Phone: (503) 945-7001

Fax: (503) 581-6198

E-mail: erinn.kelley-siel@state.or.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - **The Medical Assistance Unit.**

       Specify the unit name:

       (Do not complete item A-2)

     - **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

       Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
       Seniors and People with Disabilities (SPD)
       (Complete item A-2-a).

   - **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the division/unit name:

     In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The

interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a) The Seniors and People With Disabilities Division (SPD) operates as a Division within the Oregon Department of Human Services (the Single State Medicaid Agency). SPD is responsible for the administration of services to persons who are aged (65+), and/or physically or developmentally disabled.

   b) The Oregon Revised Statutes give clear authority to SPD serve the populations defined in (a) above.

   c) Regular and ongoing discussions with Division Assistant Director and staff. The Division Assistant Director attends weekly cabinet meetings with the Director of DHS where they address waiver-related issues as they arise.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
     Community Developmental Disability Programs (CDDPs) and Support Services Brokerages.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   - ( ) **Not applicable**
   - (●) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - [✓] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between

the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Community Developmental Disability Programs (CDDPs):
Local CDDP services coordinators perform these standardized functions:
- establish DD eligibility;
- may initially assess individuals for the ICF/MR level of care (LOC) need (Brokerages may also initially assess individuals for the need for ICF/MR LOC if circumstances change after individual is enrolled in Brokerage); and
- offer individuals the choice between ICF/MR and community-based care.

☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Local agencies can be responsible for planning and delivery of services for persons with mental retardation or other developmental disabilities in a specific geographic area of the state under a contract with the Department or a local mental health authority. Local contracted agencies operate throughout the State of Oregon in various counties and regions.

Support Services Brokerages (Organized Health Care Delivery Systems):
SPD contracts with Support Services Brokerages to oversee the assessment of individual need, write and authorize the individual plans of care, conduct initial evaluation (if not conducted by the CDDP) and annual reevaluations of the need for ICF/MR LOC, and coordinate and monitor services. The Brokerages assist individuals to access providers who deliver the waiver services described in the individual plans of care.

Brokerage organizations employ staff (Personal Agents) who provide Targeted Case Management services offered under Oregon's Medicaid State Plan.

Personal Agents, in addition to providing Medicaid State Plan Targeted Case Management services, may conduct the following waiver activities (including, but not limited to):

· The provision of direct services, such as:
~ money management, budgeting, etc.;
~ Counseling or advice about the risks associated with particular behavior or choices;
~ Supports provided while in the community with the individual;
~ Providing transportation;
~ Emergency back up support when a provider is not available;
~ Attend medical appointments; and
~ Assist with criminal/legal processes (support at court appearances, meet with Parole/Probation Officer).

· Problem Solving around (unless in the context of assessment related to plan development):
~ Personal Finances;
~ Issues relating to the FMS or employer agent;
~ Housing; and
~ Employment.

· Pre-enrollment activities; an individual must be enrolled in a brokerage to be able to provide case management services.
· Attendance at planning meeting for other types of service delivery (OVRS, IEP).
· General outreach, such as mass mailings and non-individualized information sharing.
· Clerical organization of customer files.
· Brokerage staff meetings.
· Training activities for Personal Agents.

· Communicate customer contact information changes to CDDP.
· Assist with provider recruitment/ community resource capacity development.
· Community education and outreach.
· Participate in Quality Assurance activities.
· Conduct training and provide supports to individuals regarding being an employer.

The State exercises oversight of all plans of care as part of the periodic reviews as outlined in this application.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Oregon Department of Human Services (DHS), Seniors and People with Disabilities (SPD)

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Annual Support Services Field Review- Statistically valid random sample of DDS waiver service recipients. Review conducted on-site. Review includes a review of: Individual Support Plans (ISP), Level of Care, incident reporting, provider qualifications, case documentation and individual benefit levels and rates.

Annual HCBS Waiver Review- for a statistically valid number of individuals in waiver services conducted by SPD Central Office and CDDP Quality Assurance staff---across all waivers, CDDPs, and Brokerages. Includes a review of ISPs, LOC determinations and redeterminations, and documentation to ensure that services described in the ISP were delivered. Data is submitted to SPD for central database and reporting.

Licensing or Certification Reviews— Biennially. The Department will conduct a certification review of the brokerage services prior to the renewal of the certificate. The review will be conducted 30 to 120 days prior to the expiration of the certificate.

CDDP Site Visits- formal review conducted by SPD Regional Coordinators, QA Staff, and Program Coordinators on a pre-scheduled basis every four-years to review a sample of case files and records, including brokerage clients' LOC determination information.

Office of Investigations and Training (OIT) reports– statewide data by county, type, outcome, victim, perpetrator, provider, etc.

Office of Investigations and Training (OIT) review of protective services investigations;

Serious Event Review Team (SERT) review of provider sanctions- during regularly scheduled meetings.

Contested Case Review- As requested.

SPD Complaints and Grievances Database- As requested.

DHS Audit Unit, Secretary of State- other internal or external periodic audit activities.

Improvement Projects- SPD consumer satisfaction survey of in-home service recipients conducted every 2 years.

The above-referenced Office of Investigations and Training, Licensing Unit, and SERT are all part of Department of Human Services, Oregon's single state Medicaid Agency.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐
Waiver enrollment managed against approved limits	☑	☑	☑
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☑	☑	☑
Utilization management	☑	☑	☑
Qualified provider enrollment	☑	☑	☐
Execution of Medicaid provider agreements	☑	☑	☐
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☐	☐	☐
Quality assurance and quality improvement activities	☐	☐	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of annual LOC redeterminations that are completed within the statutory 12-month time frame. Numerator: Number of annual LOC redeterminations completed within the statutory 12-month time frame. Denominator: Total number of annual LOC redeterminations.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of CDDPs and Brokerages whose contracts with the Medicaid Agency are reviewed, and, if in compliance, renewed each biennium and expressly delegate the waiver functions to be performed. Numerator: The number of Brokerages and CDDPs whose contracts have been renewed each biennium. Denominator: The total number of operating CDDPs and Brokerages.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Biennially.

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biennially.

Performance Measure:
Percentage of Brokerages and CDDPs performing waiver operations under all related rules, regulations and policies promulgated exclusively by the Medicaid Agency. Numerator: Number of Brokerages and CDDPs whose operating procedures conform to the Medicaid Agency's related rules, regulations and policies. Denominator: The total number of operating CDDPs and Brokerages.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Brokerages are reviewed annually. CDDPs are reviewed on an as needed, prescheduled basis.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Brokerages are reviewed annually. CDDPs are reviewed on an as needed, prescheduled basis.

Performance Measure:
Percentage of service plans that are updated or revised annually. Numerator: Plans that are renewed within *12 months* from the previous service plan. Denominator: All service plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Following an annual review of Brokerage files by SPD and submission of a plan of correction to SPD, SPD Support Services staff work with Brokerages to correct existing problems and to identify training needs or needed changes in practice in order to prevent future problems.
Support Service staff at SPD are involved in the appeals and fair hearings process as described in Oregon Administrative Rule. When required, the issue of the appeal is addressed in accordance with any findings. The result of the appeal is used to evaluate the relevant rules, policies and procedures governing the operation of the waiver.
Problems identified during the certification process for Brokerages are addressed by the Brokerage in a plan of correction. SPD staff follow up with the Brokerage to assure problems have been corrected.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
◉ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	18		☑
	☑	Mental Retardation	18		☑
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The cost of waiver-funded home and community-based services the individual receives cannot exceed $21,562 per plan year unless prior authorized in accordance with state administrative rules. Costs above $21,562 per plan year cannot exceed the cost of ICF/MR level of care.
Individuals are responsible for self-directing their services.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished

to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost of waiver-funded home and community-based services the individual receives cannot exceed $21,562 per plan year unless prior authorized in accordance with state administrative rules and policy. The annual costs of waiver services may not exceed the cost of ICF/MR level of care.
  The initial upper limit was derived from a waitlist lawsuit settlement that has been adjusted periodically for cost of living. The upper cost limit for this waiver is complementary to the entry point limit for accessing In-Home Services for the State's Comprehensive Residential Waiver #0117.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount: 21562

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The brokerage Personal Agents assess the waiver needs of each individual and prepare and authorize an individual plan of care. For individuals whose plan of care will exceed $21,562 per year, SPD may enroll them in the Comprehensive Services Waiver (#0117.90.R3), unless prior authorized in accordance with state administrative rules and policy.

Any time the consumer's benefits are denied, terminated or reduced they will be given notice and advised of their appeals rights. Individual service recipients- and their legal representatives - are provided timely written notice (Notice of Planned Action) of any planned change in benefits, including denial, closure or reduction. The notice includes the reason for the decision, rules that support the decision and the individual/legal representative's right to due process through a fair hearing process.

When a Notice of Planned Action is issued, the notice includes a Notice of Hearing Rights explaining how to request the continuation of benefits. When the participant requests a Medicaid Fair Hearing on the form DHS 0443, they again receive a Notice of Hearing Rights explaining how to request the continuation of benefits.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☑ **The participant is referred to another waiver that can accommodate the individual's needs.**

☑ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Individuals who have been assessed as in need of, and meeting criteria for, crisis or diversion services by the CDDP of the individual's county of residence according to OAR may receive short-term assistance with purchase of support in excess of the individual's benefits. Use of crisis or diversion services may only be authorized by the CDDP of the individual's county of residence or by the Regional Crisis Program responsible for the individual's county of residence.

Funds associated with crisis or diversion services may be used to pay the difference in cost between the authorized ISP and budget in place or purchase needed services otherwise not allowed under this waiver. The supports are authorized by either the CDDP of the individual's county of residence, or the Regional Crisis Program responsible for crisis or diversion services in the individual's county of residence, depending on the source of crisis or diversion services funds, to meet the short-term need.

Although costs for crisis or diversion services may exceed the cost limit of this waiver, in no case may the individual's costs exceed the state's current ICF/MR daily cost per individual nor may plan year expenses at or above the minimum for comprehensive services make the individual eligible for comprehensive services.

Individuals placed in emergent status due to receiving crisis or diversion services authorized and provided according to OAR may remain enrolled in, and receive support services from, the brokerage while both crisis or diversion services and support services are required to stabilize and maintain the individual at home or in the family home. In no case, however, may the individual remain enrolled in the brokerage under emergent status for more than 270 consecutive days.

The individual's personal agent must participate with CDDP or regional crisis or diversion staff in efforts to stabilize supports and return costs to the basic benefit or approved supplement levels, documenting reviews of effectiveness at least every 90 days while the individual is receiving crisis or diversion services.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7052
Year 2	7752
Year 3	8452
Year 4	9152
Year 5	9852

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ( ) **Waiver capacity is allocated/managed on a statewide basis.**
- (●) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

An individual must enter brokerage services within 90 calendar days of the date the CDDP has completed processes of eligibility determination, selection of brokerage, application, and referral to Brokerage. After a participant is enrolled in Brokerage services, the Brokerage Personal Agent has 90 days to develop the participant's service plan.
Brokerage capacity is based upon estimated enrollment projections within each Brokerage's biennial contract. Brokerages are allocated funds based upon forecasted need and contracts are updated as estimates of capacity need change.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

If an individual served under the Support Services Waiver is at imminent risk of health and safety and the supports cannot be met within the Support Services waiver, the individual can be prioritized for services in the Comprehensive Waiver.

Individuals do not reside in waiver-funded, community-based homes/residences licensed or certified by the State of Oregon. Individual cannot receive services from more than one waiver.

The cost of waiver-funded home and community-based in-home services the individual receives cannot exceed $21,562 per plan year.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  All individuals deemed to be receiving SSI under Section 1634 of the Social Security Act or other relevant sections.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- **A special income level equal to:**

  Select one:

  - **300% of the SSI Federal Benefit Rate (FBR)**
  - **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage:
  - **A dollar amount which is lower than 300%.**

    Specify dollar amount:
- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  Select one:

  - **100% of FPL**
  - **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

- **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  Select one:

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - **A percentage of the Federal poverty level**

    Specify percentage:
  - **Other standard included under the State Plan**

    Specify:
- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller Trust (Income Cap Trust).

- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable (see instructions)**
- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

  Specify the entity:

  Initial evaluations of Level of Care (LOC) may be conducted either by CDDP Services Coordinators or Brokerage Personal Agents. Annual, ongoing LOC reevaluations are conducted by Brokerage Personal Agents.
- **Other**
  Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Local CDDP Services Coordinators or Brokerage Personal Agents performing the initial level of care evaluation must be a Qualified Mental Retardation Professional, as defined in 42CFR 483.430(a); OR meet the qualifications set forth in Oregon Administrative Rule:
Per Oregon Administrative Rule, a person employed as a CDDP Services Coordinator must have knowledge of the public service system for developmental disability services in Oregon and at least:
~ A bachelor's degree in behavioral science, social science, or a closely related field; or
~ A bachelor's degree in any field AND one year of human services related experience; or
~ An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ Three years of human services related experience.

Per Oregon Administrative Rule, a person employed as a Brokerage Personal Agent must have at least:
~ An undergraduate degree in a human services field and at least one year experience in the area of developmental disabilities; or
~ Five years of equivalent training and work experience related to developmental disabilities; and
~ Knowledge of the public service system for developmental disability services in Oregon.

Persons who do not meet the minimum qualifications set forth in rule may perform those functions only with prior approval of a variance by the Department. Prior to employment of an individual not meeting minimum qualifications of a Services Coordinator or Personal Agent, the CDDP or Brokerage must submit a written variance request to the Department. The request will include:
~ An acceptable rationale for the need to employ an individual who does not meet the qualifications; and
~ A proposed alternative plan for education and training to correct the deficiencies. The proposal must specify activities, timelines and responsibility for costs incurred in completing the plan.
~ A person who fails to complete a plan for education and training to correct deficiencies may not fulfill the requirements for the qualifications.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

SPD, with the assistance of CDDPs and Brokerages, uses the Title XIX Waiver form to determine an individual's ICF/MR level of care eligibility for waivered services.

Services Coordinators (SC) at local CDDPs or Brokerage Personal Agents (PA) complete the initial Title XIX

Waiver form when an individual is entering a waivered service for the first time. Brokerage PAs review the form and reevaluate level of care annually thereafter.

The SC or PA completes the level of care form using personal observations of the individual, interviews with the individual and others with personal knowledge of the individual, and documentation of the individual's functioning, such as standardized tests administered by qualified professionals as described in OAR.
Examples include:
~ Vineland;
~ Scales of Independent Behavior – Revised (SIB-R);
~ Adaptive Behavior Assessment Scale (ABAS); and
~ Adaptive Behavior Scale (ABS);
~ The Service Coordinator's (SC) personal observations of the individual; and
~ Information from the individual's primary caregiver

SPD employs Diagnosis and Evaluation Coordinators (D & E Coordinator), to whom the SC sends the initial Title XIX Waiver form for review and LOC eligibility determination. The D & E Coordinator determines from the information provided on the Title XIX Waiver form whether the individual meets the ICF/MR level of care eligibility.

The D & E Coordinator reviews the Title XIX Waiver form to ensure:
~ That the individual has a qualifying diagnosis of a Developmental Disability; and
~ A need for supports in one or more of the following areas:
- Self Direction;
- Home Living;
- Community Use;
- Social;
- Self Care;
- Communication;
- Mobility; and
- Health & Safety.

A need for supports may include cueing, reminders, redirection, reassurance, set-up, stand-by or hands-on.

In the event the completed Title XIX Waiver form does not reflect that an individual has a need for supports in any of the areas listed above, the D & E Coordinator will contact the CDDP SC or Brokerage PA, depending on who completed the Title XIX Waiver, for more detailed information regarding the individual's functioning and need for supports. If the individual has support needs that should be reflected on the Title XIX Waiver form, the D & E Coordinator will document this information and make a determination of ICF/MR level of care eligibility.
OAR governs the criteria used to determine DD eligibility.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The above-mentioned diagnostic evaluations establish the presence of developmental disability (ies), including mental retardation. These may include evaluations by physicians, social workers, psychologists, and speech and hearing specialists. After the developmental disability has been established, the Title XIX Waiver form is completed to establish ICF/MR level of care. All individuals considered for the waiver are evaluated for ICF/MR level of care using the Title XIX Waiver form. The Title XIX Waiver form is completed for individuals discharged from an ICF/MR and for those considered for admission. The department's Diagnosis & Evaluation (D&E) Coordinators

sign all Title XIX Waiver forms and designate approval or disapproval of ICF/MR level of care.

Once Title XIX Waiver Level of Care recommendation has been made by the D&E Coordinators, the effective start date for waiver eligibility will be the latter of the following:
~ The date of the individual's signature on the Title XIX Waiver Form, or
~ The date of enrollment to a DD Home and Community-Based Waiver service.

The D&E Coordinators must be Qualified Mental Retardation Specialists with extensive knowledge of DD and DD services, with at least two years experience in program evaluation.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Brokerage Personal Agents must complete the annual Level of Care (LOC) reevaluation (Title XIX Waiver form) within the mandated 12-month time frame.

The Brokerage Personal Agent completes the LOC form for annual re-evaluation at a face-to-face meeting with the individual. This may occur at the same time as the annual ISP pre-planning meeting or at a regularly scheduled face-to-face visit no more than 60 days prior to the ISP implementation date. Completion of the annual LOC reevaluation cannot exceed 12-months from the date of the last reevaluation.

Brokerages are given the latitude to use either a tickler file system or a computer tickler system to ensure timely reevaluations of level of care (LOC). This is determined by technology available in each Brokerage or the process that works best for them on an individual basis.

SPD Central Office staff and CDDP Quality Assurance staff conduct an annual HCBS Waiver Review for a statistically valid number of individuals in waiver services. The annual HCBS Waiver Review report details aggregate data statewide, by CDDP and Brokerage. By conducting the annual HCBS Waiver Review, the state is ensuring that:
~ The TXIX Waiver Form in place;
~ The annual TXIX Waiver Form is timely and current;
~ The TXIX Waiver Form is reviewed at least annually; and
~ There is documentation present supporting eligibility and need for ICF/MR LOC
The review crosses all waivers, CDDPs and Brokerages. Data is submitted to SPD by CDDPs for entry into a central database, analysis, and reporting to utilize for prospective quality improvement activities.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Copies of initial TXIX Waiver (level of care evaluation) forms will be kept at SPD, Central Office. Original copies of the initial level of care evaluation form are kept by the entity that conducted the initial evaluation and annual reevaluation forms are kept by the Brokerage PA, in the consumer's file, at the Brokerage for a minimum period of three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of waiver applicants for whom Brokerage or CDDP staff have completed a level-of-care assessment (T.XIX waiver forms) to determine ICF/MR level of care eligibility prior to enrollment. Numerator = number of enrolled applicants who have a completed level of care assessment. Denominator = total number of enrolled applicants for Support Services waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes.

		Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of waiver participants receiving a redetermination of ICF/MR LOC prior to 12 months from their initial determination or last redetermination.
Numerator: All waiver participants with a LOC redetermination completed prior to 12 months from their initial determination or last redetermination.
Denominator: All waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of waiver participants whose waiver eligibility was determined using the appropriate processes and instruments and according to the approved description. Numerator: Waiver participants whose waiver eligibility was determined using the appropriate processes and instruments according to the approved description. Denominator: All waiver participants found eligible for services.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State Support Services Staff:
- completes a statistically valid number of file reviews annually;
- notifies Brokerage Directors and Personal Agents of need (and timeline) for correction or further documentation using the QA review form;
- conducts administrative followup to review remediation of problems; and
- provides retraining as necessary.

SPD staff enter file review data into a QI tracking spreadsheet of chart reviews, outcomes, and remediation.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Oregon assures that individuals who are eligible for services under the waiver will be informed, during the completion of the Title XIX Waiver form (Level of Care (LOC) evaluation) and eligibility process, of feasible alternatives for long-term care and given a choice as to which type of service to receive. When an individual is determined to require the level of care provided in an ICF/MR, the individual or his or her designated representative will be:

1) Informed of any feasible alternatives available under the waiver; and
2) Given the choice of either institutional or home and community-based services.

CDDP Services Coordinators or Brokerage Personal Agents, whichever conducts the initial Title XIX LOC evaluation, document the offer of choice on the initial Title XIX Waiver form. The offer of choice is given before an individual enters a waiver service. The Title XIX Waiver form is used to document that the offer of choice was presented to the individual or his/her designated representative, and how the individual or his/her designated representative indicated their choice of service. The individual’s or his/her designated representative's signature is obtained when possible.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of initial TXIX Waiver (level of care evaluation) forms will be kept at SPD, Central Office. Original copies of the initial LOC evaluation form are kept by the entity that conducted the initial evaluation and annual reevaluation forms are kept by the Brokerage PA, in the consumer’s file, at the Brokerage for a minimum period of three years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Linguistic Competence & LEP Persons

The Department of Human Services, Office of Multicultural Health provides guidance and technical assistance to DHS in fulfilling its responsibilities to provide meaningful access to limited English proficient persons (LEP). Language for LEP individuals can be a barrier to accessing important benefits or services, understanding and exercising important rights,

complying with applicable responsibilities, or understanding other information provided by Federally funded programs and activities. In certain circumstances, failure to ensure that LEP persons can effectively participate in or benefit from Federally assisted programs, may violate Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d and Title VI regulations against national origin discrimination. DHS receives funds from several Federal Agencies for an array of public health programs and services that fall under these requirements.

DHS follows the Department of Administrative Services standards. DHS is committed to improving the accessibility of these programs, services and activities to eligible LEP persons. When a Limited English Proficient (LEP) person attempts to access waiver services, Seniors and People with Disabilities notifies the person that language services are available. Seniors and People with Disabilities staff inform the LEP person that he or she has the option of having an interpreter without charge, or of using his or her own interpreter. Considerations are given to the circumstances of the LEP and whether there may be concerns over competency, confidentiality, privacy, or conflict of interest. Seniors and People with Disabilities staff do not require LEP persons to use family members or friends as interpreters.

Many vital forms and notices are available for applicants and recipients in languages that are used by a significant number of individuals in the state. Most frequently, documents are translated into Russian, Vietnamese, and Spanish and are available on the Department's website or in hard copy at the local office.

Language assistance is available for verbal communications through a contractor. Oregon DHS has also established the following Web-based resources available through DHS's web site at: www.oregon.gov/DHS/ph/omh/lep/shtml.

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations (pdf):
Designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.

Executive Order 13166[www.usdoj.gov]:
Improving Access to Services for Persons with Limited English Proficiency

Commonly Asked Questions And Answers Regarding Executive Order 13166

Multi-language Translations of Forms:
The documents on this website are intended to assist agencies that receive federal financial assistance in their planning efforts to ensure that their program services address meaningful access for all of the people they serve, including those who are limited English proficient.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Homemaker**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Extended State Plan Service	**Occupational Therapy Services**
Extended State Plan Service	**Physical Therapy Services**
Extended State Plan Service	**Speech, Hearing and Language Services**
Other Service	**Chore Services**
Other Service	**Community Living and Inclusion Support**
Other Service	**Emergent Services**
Other Service	**Environmental Accessibility Adaptations**
Other Service	**Family Training**
Other Service	**Non-Medical Transportation**
Other Service	**Personal Emergency Response Systems**
Other Service	**Special Diets**

Service Type	Service
Other Service	Specialized Medical Equipment and Supplies
Other Service	Specialized Supports
Other Service	Support Services Brokerage Operations (Organized Health Care Delivery System)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Service Definition *(Scope):*

Services consisting of general household activities (meal preparation, and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home or to allow the caregiver more time to care for the individual. Paying a homemaker to cook and clean allows the family member more time to provide hands on care. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Homemaker Provider
Agency	House Cleaning Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:
Individual Homemaker Provider
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.
General qualifications for providers of services in the family home or working directly with the individual are as follows; must be at least 18 years of age; possess ability and have sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and possess ability to communicate with the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage and participant or designated representative.
Frequency of Verification:
Upon initial enrollment as a service provider and at request of participant or designated representative.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:
House Cleaning Agency
Provider Qualifications

License *(specify):*
Business License.
Certificate *(specify):*

Other Standard *(specify):*
The Brokerage or the family will check the license status of any professional providing services to verify the license is current and unencumbered.
A representative of the Brokerage and participant or designated representative will verify that the person can provide the services needed by the individual. The family is responsible for informing and training regarding the specific care needs of the individual.
With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerages work in conjunction with the individual and family/designated representative to verify qualifications.
Frequency of Verification:
At time provider arrangements are made.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite includes both day and overnight care.

Respite care will be provided in the following locations:

~ Individual's home or place of residence;
~ Foster home (DD or non-DD);
~ Group home;
~ Residential facility approved by the State that is not a private residence:
  ~ Licensed day care center;
  ~ Respite program operated by an agency such as the Arc; OR
~ Other community care provided in a private residence of respite care provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite is an intermittent service to relieve the primary caregiver. Respite is not available to allow caregivers to attend school or work.

Respite may include the cost of room and board when it is provided in a Medicaid certified ICF/MR, or when it is provided in a foster home or community residential facility that meets state standards specified in Oregon Administrative Rule.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Respite Care Provider
Agency	Respite Care Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Respite Care Provider
Provider Qualifications

License *(specify):*
OAR 309-040-0300 through 309-040-0330; 411-360-0010 through 411-360-0310; and 411-050-0400 through 411-050-0491.
Certificate *(specify):*
OAR 416-530-0000 through 416-530-0170.
Other Standard *(specify):*
OAR 411-320-0160 and/or 411-340-0010 through 411-340-0180.
People providing direct services in the family home or working alone with a waiver recipient must pass a Criminal History Check conducted by the state. The Brokerage will check the license status of any professional providing services to verify the license is current and unencumbered.
People providing direct services in the family home or working alone with a waiver recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and have the ability to communicate with the individual.
People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance.
Must be capable of meeting the needs of the individual as determined by the family and Personal Agent. If the individual needs nursing care tasks during the time under care, this would require that the provider be a licensed nurse or a registered nurse documents in writing that the provider has been successfully delegated all the nursing tasks. Registered nurse monitoring of the delegated tasks conforms to Oregon Board of Nursing Standards. If the individual has behaviors that put the individual or others at risk, this would include the provider having sufficient training and experience to be able to respond to the unique needs of the individual. The provider is not paid to perform tasks requiring training until the training is completed.
A representative of the Brokerage or family will verify that the person can provide the care needed by the individual. The family is responsible for informing and training regarding the specific care needs of the individual.
With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage and the participant or designated representative.
Frequency of Verification:
Prior to service being provided, prior to expiration of license, if required, and at anytime the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Respite Care Provider
Provider Qualifications

License *(specify):*

OAR 309-035-0100 through 309-035-0190, 411-325-0010 through 411-325-0480, and 411-054-0000 through 411-054-0300.

Certificate *(specify):*

Other Standard *(specify):*
411-320-0160 and 411-340-0010 through 411-340-0180.

A provider organization's license under OAR chapter 411, division 325 for 24-hour residential services, or OAR chapter 411, division 360 for adult foster homes, or certified under OAR chapter 411, division 345, employment and alternatives to employment services, or OAR 309-041-0550 through OAR 309-041-0830, supported living services, may not require additional certification as an organization to provide respite, supported employment, community living, community inclusion, or emergent services.
Current license or certification may be considered sufficient demonstration of ability to:
(A) Recruit, hire, supervise and train qualified staff;
(B) Provide services according to Individual Support Plans; and
(C) Develop and implement operating policies and procedures required for managing an organization and delivering services, including provisions for safeguarding individuals receiving services.
Provider organizations must assure that all persons directed by the provider organization as employees, contractors, or volunteers to provide services paid for with support services funds meet standards for qualification of independent providers outlined in OAR.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage.

Frequency of Verification:
Prior to service being provided and prior to expiration of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

Service Definition *(Scope):*
Supported Employment Services:
Provides supports for persons for whom competitive employment is unlikely without ongoing support to perform in a work setting. Supported employment occurs in a variety of settings, particularly work sites in which persons without disabilities are employed.
Supported employment includes activities needed to obtain and sustain paid work by individuals receiving waiver services, including supervision, supports and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Co-workers who meet provider qualifications may be paid to supervise and train the individual as a result of their disabilities.

The budgets are reviewed by the Brokerage Personal Agent prior to the initiation of the service.
Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2) Payments that are passed through to users of supported employment programs; or
3) Payments for training that is not directly related to an individual's supported employment program.
Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment
Individual	Supported Employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Employment
Provider Qualifications

License *(specify):*

Certificate *(specify):*
OAR 411-345-0010 through 411-345-0300 and 411-340-0010 through 411-340-0180.
Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
DHS issues certificate. Brokerage verifies certificate is current.
Frequency of Verification:
*For employment and alternatives to employment verification is done every five years. Provider organizations are verified every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual

Provider Type:
Supported Employment

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
People providing direct services to a waiver recipient must qualify and comply with the Criminal History Check conducted by the state in accordance with Oregon Administrative Rules. The Brokerage or Supported Employment Agency will check the license status of any professional providing services to verify the license is current and unencumbered.
People providing direct services in the family home or working alone with a waiver recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and have the ability to communicate with the individual.
People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance.
Must be capable of meeting the needs of the individual as determined by the family and Personal Agent. If the individual needs nursing care tasks during the time under care, this would require that the provider be a licensed nurse or a registered nurse documents in writing that the provider has been successfully delegated all the nursing tasks. Registered nurse monitoring of the delegated tasks conforms to Oregon Board of Nursing Standards. If the individual has behaviors that put the individual or others at risk, this would include the provider having sufficient training and experience to be able to respond to the unique needs of the individual. The provider is not paid to perform tasks requiring training until the training is completed.
A representative of the Brokerage or family will verify that the person can provide the care needed by the individual. The family is responsible for informing and training regarding the specific care needs of the individual.
With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage.

Frequency of Verification:
Prior to service being provided and at anytime the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:
Occupational Therapy Services
Service Definition *(Scope):*
Development of an individual's fine motor skills.
Services that are provided when the limits of Occupational Therapy under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Occupational Therapy services furnished under the State plan. The provider qualifications specified in the State plan apply.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational therapy is provided according to a plan of treatment. Division of Medical Assistance Programs (DMAP) Physical and Occupational Therapy Guide describes services provided, prior authorization requirements, and limitations of services and payments.
Services for physical therapy, occupational therapy, speech therapy, hearing services, nursing services, and mental health services must be recommended by a physician or other practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist, occupational therapist, speech pathologist, audiologist, Nurse, Nurse Practitioner, Psychiatrist, Psychologist, or Social Worker qualified and licensed to deliver the service.
Medicaid covered services and treatments are provided in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an approved plan of care.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Professionals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy Services

Provider Category:
Individual
Provider Type:
Licensed Professionals
Provider Qualifications
License *(specify):*
ORS 675.240
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Occupational Therapy Licensing Board.
Brokerage.
Frequency of Verification:
Licenses shall expire on May 31 of even-numbered years. The Occupational Therapy Licensing Board shall license any person who meets the requirements of ORS 675.210 to 675.340 upon payment of a license fee in an amount established by the board.
Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Physical Therapy Services
Service Definition *(Scope):*
Development of an individual's gross motor skills.
Services that are provided when the limits of Physical Therapy under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Physical Therapy services furnished under the State plan. The provider qualifications specified in the State plan apply.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Physical therapy is provided according to a plan of treatment. DMAP Physical and Occupational Therapy Guide describes services provided, prior authorization requirements, and limitations of services and payments.
Services for physical therapy, occupational therapy, speech therapy, hearing services, nursing services, and mental health services must be recommended by a physician or other practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist, occupational therapist, speech pathologist, audiologist, Nurse, Nurse Practitioner, Psychiatrist, Psychologist, or Social Worker qualified and licensed to deliver the service.
Medicaid covered services and treatments are provided in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an approved plan of care.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy Services

Provider Category:
Individual
Provider Type:
Licensed Professional
Provider Qualifications
License *(specify):*
ORS 688.020 and OAR 848-010-0010 through 848-010-0044.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Physical Therapist Licensing Board.
Brokerage.
Frequency of Verification:
Annually.
Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Speech, Hearing and Language Services
Service Definition *(Scope):*
Development of an individual's speech, language and hearing skills.
Services that are provided when the limits of Speech, Hearing and Language Services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Speech, Hearing and Language Services furnished under the State plan. The provider qualifications specified in the State plan apply.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Speech pathology or audiology services are provided according to a plan of treatment. DMAP Speech Language Pathology, Audiology and Hearing Aid Services Guide describes services provided, prior authorization requirements, and limitations of services and payments.
Services for physical therapy, occupational therapy, speech therapy, hearing services, nursing services, and mental health services must be recommended by a physician or other practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the supervision of a qualified physical therapist, occupational therapist, speech pathologist, audiologist, Nurse, Nurse Practitioner, Psychiatrist, Psychologist, or Social Worker qualified and licensed to deliver the service.
Medicaid covered services and treatments are provided in accordance with Oregon's Medicaid program's Prioritized List of Health Services to recipients receiving services pursuant to an approved plan of care.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Professionals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual
Provider Type:
Licensed Professionals
Provider Qualifications
License *(specify):*
ORS 681.250.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
State Board of Examiners for Speech-Language Pathology and Audiology.
Brokerage.
Frequency of Verification:
On or before January 30 of each even-numbered year, each licensed speech-language pathologist or audiologist shall submit to the State Board of Examiners for Speech-Language Pathology and Audiology an application for renewal of license and pay the renewal fee established by the board. Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Chore Services

Service Definition *(Scope):*
Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore Provider
Individual	Chore Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Agency

Provider Type:
Chore Provider

Provider Qualifications

License *(specify):*
Business License.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerages work in conjunction with the individual and family/designated representative to verify qualifications.

Frequency of Verification:

At time provider arrangements are made.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Individual
Provider Type:
Chore Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.
General qualifications for providers of services in the family home or working directly with the individual are as follows; must be at least 18 years of age; possess ability and have sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and possess ability to communicate with the individual.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage and participant or designated representative.
Frequency of Verification:
Upon initial enrollment as a service provider and at request of participant or designated representative.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Living and Inclusion Support
Service Definition *(Scope):*
To facilitate independence and promote community integration by supporting the individual to gain or maintain skills to live as independently as possible in the type of home the individual chooses and to provide support for the individuals to participate in activities in integrated settings that promote community inclusion and contribution.

This service includes support with personal skills, socialization, recreation and leisure, communication, participation in the community, and personal environmental skills, designed to develop or maintain skills for self-care, ability to direct supports, and care of the immediate environment.

Support with personal skills includes eating, bathing, dressing, personal hygiene and/or mobility.

Support with socialization includes development or maintenance of self-awareness and self control, social responsiveness, social amenities, and interpersonal skills.

Support with community participation, recreation or leisure includes the development or maintenance of skills to use available community services, facilities, or businesses.

Support with communication includes development or maintenance of expressive and receptive skills in verbal and non-verbal language and the functional application of acquired reading and writing skills.

Support with personal environmental skills includes development or maintenance of skills such as planning and preparing meals, budgeting, laundry, and housecleaning.

Supports may or may not be work related. When applicable, wages are paid in accordance with labor laws. Supports may include instruction in skills an individual wishes to acquire, retain or improve that enhance independence, productivity, integration and or maintain the individual's physical and mental skills.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living and Inclusion Provider
Individual	Community Living and Inclusion Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Inclusion Support

Provider Category:
Agency
Provider Type:
Community Living and Inclusion Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*
OAR 411-340-0010 through 411-340-0180.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage.

Frequency of Verification:
Biennially.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Inclusion Support

Provider Category:
Individual

Provider Type:
Community Living and Inclusion Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.
General qualifications for providers of services in the family home or working directly with the individual are as follows; must be at least 18 years of age; possess ability and have sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and possess ability to communicate with the individual.
Individuals providing transportation must also have a valid driver's license, a good driving record, and proof of insurance.
If the individual needs nursing care tasks during the time under care, this would require that the provider be a licensed nurse or a registered nurse documents in writing that the provider has been successfully delegated all the nursing tasks. Registered nurse monitoring of the delegated tasks conforms to Oregon Board of Nursing Standards. If the individual has behaviors that put the individual or others at risk, this would include the provider having sufficient training and experience to be able to respond to the unique needs of the individual. The provider is not paid to perform tasks requiring training until the training is completed.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage, participant or designated representative.

Frequency of Verification:
Upon initial enrollment as a service provider and at request of participant or designated representative.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Emergent Services

Service Definition *(Scope):*

Emergent services are for individuals in jeopardy of losing their living situation due to inability or unavailability of the primary caregiver, and no alternative resources are available.

Individuals who have been assessed as in need of, and meeting criteria for, crisis or diversion services by the CDDP of the individual's county of residence according to OAR may receive short-term assistance with purchase of support in excess of the individual's benefits. Use of crisis or diversion services may only be authorized by the CDDP of the individual's county of residence or by the Regional Crisis Program responsible for the individual's county of residence.

Funds associated with crisis or diversion services may be used to pay the difference in cost between the authorized ISP and budget in place or purchase needed services otherwise not allowed under this waiver. The supports are authorized by either the CDDP of the individual's county of residence, or the Regional Crisis Program responsible for crisis or diversion services in the individual's county of residence, depending on the source of crisis or diversion services funds, to meet the short-term need.

Although costs for crisis or diversion services may exceed the cost limit of this waiver, in no case may the individual's costs exceed the state's current ICF/MR daily cost per individual nor may plan year expenses at or above the minimum for comprehensive services make the individual eligible for comprehensive services.

Individuals placed in emergent status due to receiving crisis or diversion services authorized and provided according to OAR may remain enrolled in, and receive support services from, the brokerage while both crisis or diversion services and support services are required to stabilize and maintain the individual at home or in the family home. In no case, however, may the individual remain enrolled in the brokerage under emergent status for more than 270 consecutive days.

The individual's personal agent must participate with CDDP or regional crisis or diversion staff in efforts to stabilize supports and return costs to the basic benefit or approved supplement levels, documenting reviews of effectiveness at least every 90 days while the individual is receiving crisis or diversion services.

SPD policies and business structures do not allow an individual to be on more than one waiver at a time.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergent Services Provider
Individual	Emergent Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergent Services

Provider Category:
Agency
Provider Type:
Emergent Services Provider
Provider Qualifications
License *(specify):*
OAR 309-035-0100 through 309-035-0190, 411-054-0000 through 411-054-0300, 411-325-0010 through 411-325-0480.
Certificate *(specify):*
OAR 411-340-0010 through 411-340-0180 and 411-345-0010 through 411-345-0300.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage or CDDP.
Frequency of Verification:
As defined in each OAR governing the qualifications of providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergent Services

Provider Category:
Individual
Provider Type:
Emergent Services Provider
Provider Qualifications
License *(specify):*
OAR 309-040-0300 through 309-040-0455; 411-360-0010 through 411-360-0310; and 411-050-0400 through 411-050-0491.
Certificate *(specify):*
416-530-0000 through 416-530-0170.
Other Standard *(specify):*
People providing direct services in the family home or working alone with a waiver recipient must pass a Criminal History Check conducted by the state. The Brokerage or the family will check the license status of any professional providing services to verify the license is current and unencumbered.
People providing direct services in the family home or working alone with a waiver recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and have the ability to communicate with the individual. People providing transportation must also be at least 18 years of age, have a valid driver's license, a good driving record, and proof of insurance.
A representative of the Brokerage or family will verify that the person can provide the care needed

by the individual. The family is responsible for informing and training regarding the specific care needs of the individual.

With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Brokerage or CDDP.

Frequency of Verification:

As defined in each OAR governing the qualifications of providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

Service Definition *(Scope):*

Those physical adaptations to the private residence of the participant or the participant's family, required by the individual's plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, or to provide for a cost-effective long term plan of care. Such adaptations may include the installation of ramps and grab-bars, removing or widening of doorways, handrails, electric door openers, adaptations of kitchen cabinets/sinks, modifications of bathroom facilities, individual room air conditioners to maintain stable temperature as required by the individual's medical condition, installation of non-skid surfaces, overhead track systems to assist with lifting or transferring of individuals, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

All services shall be provided in accordance with applicable State or local building codes. Environmental modification consultation necessary to evaluate the home and make plans to modify the home to ensure the health and safety of the individual is included.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Building Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Building Contractor
Provider Qualifications
License *(specify):*
Licensed contractors under OAR 812-001-0000 through 812-011-0070 and 808-001-0000 through 808-009-0440.
Certificate *(specify):*

Other Standard *(specify):*
Environmental accessibility adaptations will be done by licensed and bonded contractors.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerages work in conjunction with the individual and family/designated representative to verify qualifications.
Frequency of Verification:
At time of initial employment or when services are rendered.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Family Training
Service Definition *(Scope):*
Family training services are training and counseling services provided to the family of an individual with developmental disabilities who is self-directing his or her own services, to increase their capabilities to care for, support and maintain the individual in the home.
"Family" for determining who may receive family training, means a unit of two or more persons that includes at least one person with developmental disabilities where the primary caregiver(s) is(are):
(a) Related to the individual with developmental disabilities by blood, marriage or legal adoption; or
(b) In a domestic relationship where partners share:
(A) A permanent residence;
(B) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and
(C) Joint responsibility for supporting a member of the household with disabilities related to one of the partners by blood, marriage, or legal adoption.

Family training services include, but are not limited to: instruction about treatment regimens and use of

equipment specified in the Individual Support Plan (ISP); information, education and training about the individual's disability, medical, and behavioral conditions. Family training services may be provided in various settings by various means, including but not limited to: psychologists licensed under ORS 675.030; professionals licensed to practice medicine under 677.100 or nursing under 678.040; social workers licensed under 675.530; counselors licensed under 675.715; organized conferences and workshops specifically related to the individual's disability.
~ Family training supports do not duplicate any other waiver service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Prior authorization is required by Brokerage for attendance by family members at organized conferences and workshops.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Health Educator: Organized Conferences and Workshops
Individual	Social Worker
Individual	Mental Health Professional: Counselor
Individual	Licensed Psychologists
Individual	Health Educator: Physician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:
Health Educator: Organized Conferences and Workshops
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Payment for families to attend organized workshops and conferences is limited to topics that are related to the individual's disability, identified support needs, or specialized medical or behavior support needs.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage.
Frequency of Verification:
Upon initial enrollment as a provider, as license or certificate expires and is renewed, and at any other time a need or reason for review is identified.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:
Social Worker
Provider Qualifications
License *(specify):*
ORS 675.530.
Certificate *(specify):*

Other Standard *(specify):*
Family training will be done by licensed providers, contracted training and technical assistance agencies, or individuals with documented specialty experience.

With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage.
Frequency of Verification:
Upon initial enrollment as a provider, as license or certificate expires and is renewed, and at any other time a need or reason for review is identified.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:
Mental Health Professional: Counselor
Provider Qualifications
License *(specify):*
ORS 675.715
Certificate *(specify):*

Other Standard *(specify):*
Family training will be done by licensed providers, contracted training and technical assistance agencies, or individuals with documented specialty experience.

With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage and individual or family member/designated representative.
Frequency of Verification:
Upon initial enrollment as a provider, as license or certificate expires and is renewed, and at any other time a need or reason for review is identified.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:
Licensed Psychologists
Provider Qualifications
License *(specify):*
ORS 675.030
Certificate *(specify):*

Other Standard *(specify):*
Family training will be done by licensed providers, contracted training and technical assistance agencies, or individuals with documented specialty experience.
People providing direct services in the family home or working alone with a waiver recipient must pass a Criminal History Check conducted by the state. The Brokerage or the family will check the license status of any professional providing services to verify the license is current and unencumbered.
With cause, providers may be subject to investigation or inquiries by the CDDP, the Department or the appropriate licensing authority.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage and individual or family member/designated representative.
Frequency of Verification:
Upon initial employment or rendering of service, as license or certificate expires and is renewed, and at any other time a need or reason for review is identified.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:
Health Educator: Physician
Provider Qualifications
License *(specify):*
ORS 677.100
Certificate *(specify):*

Other Standard *(specify):*
Family training will be done by licensed providers, contracted training and technical assistance agencies, or individuals with documented specialty experience.
People providing direct services in the family home or working alone with a waiver recipient must pass a Criminal History Check conducted by the state. The Brokerage or the family will check the license status of any professional providing services to verify the license is current and

unencumbered.
With cause, providers may be subject to investigation or inquiries by the CDDP, the Department, or the appropriate licensing authority.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage and individual or family member/designated representative.

Frequency of Verification:
Upon initial enrollment as a provider, as license or certificate expires and is renewed, and at any other time a need or reason for review is identified.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Non-Medical Transportation

Service Definition *(Scope):*
Transportation of individuals to leisure activities, day habilitation services, Supported Employment, non-medical appointments, and various related services in accordance with the individual's plan of care.
No payment will be made to a spouse for these services; the cost of purchasing or leasing family vehicles will not be charged to the waiver. Cost associated with transportation services rendered by residential or employment providers may be included in the rate established for such services. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Bus / Taxi

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
Valid Driver's License.
Certificate *(specify):*

Other Standard *(specify):*
Individuals providing transportation must be at least 18 years of age, have a valid driver's license, a good driving record, and proof of insurance.
People providing direct services in the family home or working alone with a waiver recipient must pass a Criminal History Check conducted by the state. The Brokerage or the family will check the license status of any professional providing services to verify the license is current and unencumbered.
People providing direct services in the family home or working alone with a waiver recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and have the ability to communicate with the individual.
A representative of the Brokerage or family will verify that the person can provide the care needed by the individual. The family is responsible for informing and training regarding the specific care needs of the individual.
With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage.
Frequency of Verification:
Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Bus / Taxi
Provider Qualifications
License *(specify):*
Business License.
Certificate *(specify):*

Other Standard *(specify):*
411-340-0010 through 411-340-0180.
In accordance with established standards.
Transportation provided by common carriers, taxicab or bus will be in accordance with standards established for those entities.
With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage and participant or designated representative.

Frequency of Verification:
At time provider arrangements are made.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response Systems

Service Definition *(Scope):*
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone
and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. This may also include the cost to purchase and use cell phones as a means of securing help in an emergency situation when the individual is outside the home and needs assistance due to accident, injury, or inability to find the way home. Cell phones are not for convenience or general purpose use, and costs associated with non-emergency usage are excluded.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vendors and Supply Companies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Individual
Provider Type:
Vendors and Supply Companies
Provider Qualifications
License *(specify):*
Business License.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerages work in conjunction with the individual and family/designated representative to verify qualifications.
Frequency of Verification:
At time provider arrangements are made.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Special Diets
Service Definition *(Scope):*
Specially prepared food and/or particular types of food needed to sustain the individual in the family home. Special diets can include high caloric supplements; gluten free supplements; diabetic, ketogenic or other metabolic supplements. Special diets must be ordered by a physician and periodically monitored by a dietician. Special diets will not constitute a full nutritional regimen; meals as such will not be provided.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors and Supply Companies
Individual	Licensed Dietitian

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Special Diets

Provider Category:
Agency
Provider Type:
Vendors and Supply Companies
Provider Qualifications
License *(specify):*
Business License.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage and participant or designated representative.
Frequency of Verification:
At time provider arrangements are made.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Special Diets

Provider Category:
Individual
Provider Type:
Licensed Dietitian
Provider Qualifications
License *(specify):*
ORS 691.415 through 691.465.
Certificate *(specify):*

Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.

Verification of Provider Qualifications

Entity Responsible for Verification:
Board of Examiners of Licensed Dietitians.
Brokerage.

Frequency of Verification:
Biennially.
Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Specialized Medical Equipment and Supplies

Service Definition *(Scope):*
Specialized medical equipment and supplies to include cost-efficient devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.
All items shall meet applicable standards of manufacture, design and installation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors / Medical Supply Companies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Vendors / Medical Supply Companies
Provider Qualifications
License *(specify):*
Supplies only: have a business license.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Specialized medical equipment or supplies will be obtained from qualified vendors.
Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage and individual or family member/designated representative.
Frequency of Verification:
At time of initial contract or purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Supports
Service Definition *(Scope):*
Specialized supports for the purpose of providing treatment, training, consultation or other unique services necessary to achieve outcomes in the plan of care that are not available through State Plan services or other waiver services. For example: behavior consultation consisting of assessment of the individual, the needs of the family and the environmental factors that affect behavior; development of a positive behavior support plan, training and implementation of a positive behavior support plan with the family and providers, and revision and monitoring of the plan as needed to prevent injury to the individual or others. Social sexual consultation to assess the individual and the environmental factors that effect the behavior; develop a support plan with the individual, family and providers; implement, train, monitor and revise the plan as needed to meet the identified outcomes of the plan. Licensed nurse services to assess the individual; develop a support plan with the individual, family and providers; implement, train, monitor, and revise the plan as needed to meet the identified outcomes of the plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Social Sexual Consultant
Individual	Nurse
Agency	Behavior Consultant
Agency	Nurse
Individual	Behavior Consultant
Agency	Social Sexual Consultants

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Supports

Provider Category:
Individual
Provider Type:
Social Sexual Consultant
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.
General qualifications for providers of services in the family home or working directly with the individual are as follows; must be at least 18 years of age; possess ability and have sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and possess ability to communicate with the individual.

Specialized Supports:
Social/sexual consultant must have a minimum of the following:
a. the education, skills, and abilities necessary to provide social/sexual consultation services; and
b. submit a resume to the brokerage indicating at least one of the following:
(I) a bachelor's degree in Special Education, Psychology, Social Work, Counseling or other behavioral science field and at least one year of experience with people with developmental

disabilities, or
(II) three years experience with people with developmental disabilities who present social or sexual issues and at least one year of that experience must include providing the services of a social/sexual consultant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage.

Frequency of Verification:
Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Supports

Provider Category:
Individual

Provider Type:
Nurse

Provider Qualifications

License *(specify):*
ORS 678.010 through 678.101

Certificate *(specify):*

Other Standard *(specify):*
Individuals, including family members, and agencies providing direct services in the family home, or working directly with the individual, will become Qualified Providers by meeting general and specific qualifications, passing a Criminal History Check, and a check of any applicable professional agency to verify that the license or certificate is current and unencumbered.
General qualifications for providers of services in the family home or working directly with the individual are as follows; must be at least 18 years of age; possess ability and have sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and possess ability to communicate with the individual.
Nursing consultant must have a minimum of the following:
a. the education, skills, and abilities necessary to provide nursing services in accordance with State Law; and
b. submit a resume to the brokerage indicating a current Oregon nursing license and at least one year of experience with people with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oregon Board of Nursing.
Brokerage.

Frequency of Verification:
Upon initial enrollment as a service provider, at expiration of license, and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Supports

Provider Category:

Agency

Provider Type:

Behavior Consultant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

411-340-0010 through 411-340-0180.

Verification of Provider Qualifications

Entity Responsible for Verification:

Brokerage.

Frequency of Verification:

At time of provider arrangement; subject to the guidelines of the Oregon Intervention System (OIS) statewide steering committee; and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Supports

Provider Category:

Agency

Provider Type:

Nurse

Provider Qualifications

License *(specify):*

ORS 678.010 through 678.101 and 443.015 trough 443.095.

Certificate *(specify):*

Other Standard *(specify):*

411-340-0010 through 411-340-0180.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oregon Board of Nursing.
Brokerage.

Frequency of Verification:

Biennially.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Supports

Provider Category:

Individual

Provider Type:
Behavior Consultant
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
OAR 411-340-0010 through OAR 411-340-0180.

Behavior consultants providing specialized supports must:
(a) Have education, skills, and abilities necessary to provide behavior consultation services, including knowledge and experience in developing plans based on positive behavioral theory and practice;
(b) Have received at least two days of training in the Oregon Intervention Systems (OIS), behavior intervention system, and have a current certificate; and
(c) Submit a resume to the Brokerage indicating at least one of the following:
(A) A bachelor's degree in Special Education, Psychology, Speech and Communication, Occupational Therapy, Recreation, Art or Music Therapy, or a behavioral science field and at least one year of experience with people with developmental disabilities who present difficult or dangerous behaviors; or
(B) Three years experience with people with developmental disabilities who present difficult or dangerous behaviors and at least one year of that experience must include providing the services of a behavior consultant.

People providing direct services in the family home or working alone with a waiver recipient must pass a Criminal History Check conducted by the state.
People providing direct services in the family home or working alone with a waiver recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; and have the ability to communicate with the individual.
A representative of the Brokerage or family will verify that the person can provide the care needed by the individual. The family is responsible for informing and training regarding the specific care needs of the individual.
With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage and participant or designated representative.
Frequency of Verification:
At time of provider arrangement; subject to the guidelines of the Oregon Intervention System (OIS) statewide steering committee; and at any time the participant or designated representative requests.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Supports

Provider Category:
Agency
Provider Type:
Social Sexual Consultants

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
411-340-0010 through 411-340-0180.

Verification of Provider Qualifications

Entity Responsible for Verification:
Brokerage.

Frequency of Verification:
Prior to delivery of service and prior to expiration of the license.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Support Services Brokerage Operations (Organized Health Care Delivery System)

Service Definition *(Scope):*
SPD contracts with Support Services Brokerages (Brokerage) to perform functions as identified in Oregon Administrative Rules.
Brokerages must provide or arrange for the following services as required to meet individual support needs:
· Assistance for individuals to determine needs, plan supports in response to needs, and develop individualized budgets based on available resources;
· Assistance for individuals to find and arrange the resources to provide planned supports;
· Assistance with development and expansion of community resources required to meet the support needs of individuals served by the brokerage;
· Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct providers;
· Fiscal intermediary activities in the receipt and accounting of support services funds on behalf of an individual in addition to making payment with the authorization of the individual;
· Employer-related supports, assisting individuals to fulfill roles and obligations as employers of support staff when plans call for such arrangements; and
· Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

Brokerages also assist the participant in verifying that providers are qualified to deliver waiver services.

Brokerages employ Personal Agents who, in addition to providing State Plan Targeted Case Management services, may conduct the following activities (including, but not limited to):
· The provision of direct services, such as:
~ Money management, budgeting, etc.;
~ Counseling or advice about the risks associated with particular behavior or choices;
~ Supports provided while in the community with the individual;
~ Providing transportation;
~ Emergency back up support when a provider is not available;

~ Attend medical appointments; and
~ Assist with criminal/legal processes (support at court appearances, meet with Parole/Probation Officer).

· Problem Solving around (unless in the context of assessment related to plan development):
~ Personal Finances;
~ Issues relating to the FMS or employer agent;
~ Housing; and
~ Employment.

· Pre-enrollment activities; an individual must be enrolled in a brokerage to be able to provide case management services.
· Attendance at planning meeting for other types of service delivery (OVRS, IEP).
· General outreach, such as mass mailings and non-individualized information sharing.
· Clerical organization of customer files.
· Brokerage staff meetings.
· Training activities for Personal Agents.
· Communicate customer contact information changes to CDDP.
· Assist with provider recruitment/ community resource capacity development.
· Community education and outreach.
· Participate in Quality Assurance activities.
· Conduct training and provide supports to individuals regarding being an employer.

Brokerage staff conduct reviews of Personal Agents' activities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Services Brokerage / Provider Organization
Individual	Support Services Brokerages Personal Agents

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Services Brokerage Operations (Organized Health Care Delivery System)

Provider Category:
Agency
Provider Type:
Support Services Brokerage / Provider Organization
Provider Qualifications
License *(specify):*

Certificate *(specify):*
OAR 411-340-0010 through 411-340-0180.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHS.
Frequency of Verification:
Until November 14, 2008: biennially. On or after November 15, 2008: every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Services Brokerage Operations (Organized Health Care Delivery System)

Provider Category:
Individual
Provider Type:
Support Services Brokerages Personal Agents
Provider Qualifications
License *(specify):*

Certificate *(specify):*
411-340-0010 through 411-340-0180.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Brokerage.
Frequency of Verification:
Upon initial employment.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Support Services Brokerage Personal Agents.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Oregon Revised Statutes and Oregon Administrative Rules authorize DHS to conduct reasonable screening to determine whether potential and current providers of care related services have a history of criminal behavior such that they should not be allowed to oversee, live or work closely with, or provide services to vulnerable people. OAR states that SPD conducts, or requires contractors to conduct, such criminal records checks on persons identified as “Subject Individuals” which include:
~ An employee of the Department, person who has been offered employment by the Department, volunteer or student over whom the Department has direction and control.
~ A person who is licensed, certified, registered or otherwise regulated or authorized for payment by the Department and who provides care.
~ An employee or volunteer who provides care within any entity or agency licensed, certified, registered or otherwise regulated by the Department.
~ A direct care staff person secured through the services of a personnel services or staffing agency who works in any long term care facility licensed by the Department pursuant to ORS chapter 441.
~ Except as provided in rule, a person who lives in a facility that is licensed, certified, registered or otherwise regulated by the Department to provide care.
~ A homecare worker, personal care services provider or an independent provider employed by a Department client and who provides services to the client if the Department helps to pay for the services.
~ A contact person or authorized designee as defined in OAR.
~ A person providing training to staff within a long term care facility.
~ Any person serving as an owner, operator or manager of a room and board facility pursuant to OAR chapter 411, division 68.
~ Any person applying for a paid or volunteer position, any employee, any volunteer, any contractor, or any employee of any contractor of a State-operated group home within the Department's State-Operated Community Programs, Eastern Oregon Psychiatric Center, Eastern Oregon Training Center, and Oregon State Hospital.
~ Any person who is required to complete a criminal history check pursuant to a contract or written agreement with the Department or by other Oregon Administrative Rules of the Department, if the requirement is within the statutory authority granted to the Department. Specific statutory authority must be specified in the contract.

(b) All screenings include information obtained from the Oregon State Police Law Enforcement Data System, but DHS obtains from other sources and states the information necessary to complete the work. DHS may require a national search using fingerprints and the FBI database under several circumstances: out-of-state residency for 60 or more consecutive days during the previous three years; indication of criminal history outside Oregon; or there is some question of identity or history. DHS-authorized designees make final fitness determinations using a weighing test based on law enforcement data provided from the DHS Criminal Records Unit concerning past arrests and convictions as well as mitigating circumstances (e.g. rehabilitation, diversion,

time passed since conviction or arrest). Criminal background screenings are typically conducted prior to execution of provider agreements and at intervals thereafter based on rules for the service provided and at any time DHS has reason to believe that re-screening is required.

(c) The DHS Criminal Records Unit (CRU) has developed standard forms and processes to initiate and conduct criminal background screening. The CRU approves all persons authorized by DHS ("authorized designees") to conduct screenings based on criminal background checks and satisfactory completion of CRU-provided training on standard forms, processes, information sources and implications, and factors to consider in weighing tests. Additionally, provider payment is linked to continued compliance with criminal history review standards:
~ Organizations using authorized designees as defined in Oregon Adminsitrative Rule authorize payment to direct care providers based on initial fitness determination; and
~ Licensed or certified provider enrollment payment is suspended when license or certificate expires unless SPD worker enters information that license or certificate has been renewed. Licensing and certification processes involve sampling personnel files for evidence criminal background review and fitness determinations according to DHS policy.
SPD, Support Services Staff conduct annual field reviews of Brokerages, during which a statistically valid random sample of files are reviewed. Part of the review includes ensuring that the criminal background checks for providers have been completed.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- **No. The State does not conduct abuse registry screening.**
- **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Adult Group Care Home	
Non-Relative Adult Foster Care	
Assisted Living Facility	
Residential Care Facility	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

~ Non-Relative Adult Foster Care:
Foster Care Homes are responsible for providing up to 24 hours of care, supervision, and training to individuals with developmental disabilities. Support provides assistance with activities of daily living (ADL) and help individuals access other community resources that increase their integration and independence. Services are in a family home, but not the home of a parent, guardian, or family member.
Services are provided in settings of five or fewer individuals in care in a single home and must be appropriate to the needs, preferences, age and condition of the individual residents. These homes are generally indistinguishable from their neighbors in communities throughout the state. Cooking, dining, and common areas are typical in scale and use of family homes in the area, with access limited only by specific individual resident safety concerns. No more than two residents share a bedroom. Assistance with ADLs is conducted privately. Residents associate and communicate privately with any person of choice. Providers are required to make available at least six hours of activities each week oriented to individual interests, not including television and movies. Residents also have access to, and participate in, activities of chosen social, religious and community groups.
~ Adult Group Homes:
Residential facilities in the community designed to provide 24-hour supervised care, training and support for individuals with developmental disabilities. Group homes can vary in the number of individuals who live there and the number of staff, depending on the support needs of the individuals. There are some group homes designed to serve individuals with complex medical needs, as well as those with challenging behavioral needs.
Most group homes are operated by private, non-profit agencies, while some group homes are operated by the State (State Operated Community Programs (SOCP)).
These homes are generally indistinguishable from their neighbors in communities throughout the state. Cooking, dining, and common areas are typical in scale and use of family homes in the area, with access limited only by specific individual resident safety concerns. No more than two residents share a bedroom. Assistance with ADLs is conducted privately. Residents associate and communicate privately with any person of choice. Providers are required to make available at least six hours of activities each week oriented to individual interests, not including television and movies. Residents also have access to, and participate in, activities of chosen social, religious and community groups.
Room and Board is funded by an individual's Social Security or other income source and is not paid using TXIX funds.
~Assisted Living Facilities:
Administrative rules under which Assisted Living Facilities are regulated require each facility to deliver services and design the physical environment in ways that support resident dignity, independence, individuality, privacy, choice and decision-making abilities. “Home” in these rules is defined as a living environment which creates an atmosphere supportive of the resident’s preferred lifestyle and is supported by the use of residential building materials and furnishings.
Personalized care is furnished to individuals who reside in their own living units which are separate and distinct from each other. Units may be dually occupied only when both occupants consent to the arrangement. Units include kitchenette and/or living rooms as well as bedrooms and toilet facilities. Resident laundry facilities, unit mailboxes, and telephone lines in each unit are provided. Personal living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms).
~ Residential Care Facilities:
Residential Care Facilities provide a wide range of services in a shared, homelike environment designed to enhance the dignity, independence, individuality, and decision-making ability of the residents in a safe, secure environment. Resident units may be comprised of individual apartments with private bathroom and kitchenette. If resident units are limited to private or semi-private bedroom only, then bathroom facilities are centrally located off common corridors. In all cases, separate wardrobe closets are provided for each resident’s clothing and personal belongings. Separate resident laundry facilities have been provided in all facilities licensed on or after January 1, 1994, allowing residents to schedule use for personal laundry. If phones must be located in a staff area, the phone must be available for normal resident use at any time and ensure resident privacy during the call. Common dining and living

areas are furnished in a homelike manner. An accessible outdoor recreation area is required and must be available for all residents to use.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Group Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	☐
Specialized Supports	☐
Occupational Therapy Services	☐
Chore Services	☐
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐
Supported Employment	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Community Living and Inclusion Support	☐
Respite	☑
Speech, Hearing and Language Services	☐
Non-Medical Transportation	☐
Family Training	☐
Special Diets	☐
Emergent Services	☑
Homemaker	☐

Facility Capacity Limit:

The vast majority of residential settings have a capacity of 5 or fewer residents who are MR/DD and are not related to the provider by blood or marriage. A few settings range from 6 to 20 residents.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑

Standard	Topic Addressed
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Non-Relative Adult Foster Care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	☐
Specialized Supports	☐
Occupational Therapy Services	☐
Chore Services	☐
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐
Supported Employment	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Community Living and Inclusion Support	☐
Respite	☑
Speech, Hearing and Language Services	☐
Non-Medical Transportation	☐
Family Training	☐
Special Diets	☐
Emergent Services	☑

Waiver Service	Provided in Facility
Homemaker	☐

Facility Capacity Limit:

Five or fewer individuals with MR/DD who are not related to the provider by blood or marriage.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	☐
Specialized Supports	☐
Occupational Therapy Services	☐
Chore Services	☐
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐
Supported Employment	☐

Waiver Service	Provided in Facility
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Community Living and Inclusion Support	☐
Respite	☑
Speech, Hearing and Language Services	☐
Non-Medical Transportation	☐
Family Training	☐
Special Diets	☐
Emergent Services	☑
Homemaker	☐

Facility Capacity Limit:

None

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

OAR requires the Assisted Living Facility to “have qualified staff sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident and respond to emergency situations”. Overall staffing ratios have not been prescribed for Assisted Living Facilities because residents are typically independent in many areas, with needs varying from site to site, and so the minimum number of staff required to meet resident needs at all sites is not predictable. If the facility is not meeting the needs of the residents, either by failing to provide scheduled services or to respond to emergencies, SPD determines staffing to be inadequate. SPD is made aware of issues that might lead to this determination primarily through: 1) Personal Agents' monitoring of individual plan implementation; 2) surveyor observations and other data collected during licensing reviews; and 3) protective services activity.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	☐
Specialized Supports	☐
Occupational Therapy Services	☐
Chore Services	☐
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐
Supported Employment	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Community Living and Inclusion Support	☐
Respite	☑
Speech, Hearing and Language Services	☐
Non-Medical Transportation	☐
Family Training	☐
Special Diets	☐
Emergent Services	☑
Homemaker	☐

Facility Capacity Limit:

None

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑

Standard	Topic Addressed
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  As with any other provider of waiver services, a relative or legal guardian is required to meet the same qualifications set forth in Oregon Administrative Rule. Relatives or legal guardians designated as providers are specified in the service plan and verified as being in the best interest of the consumer. Time sheets and/or invoices that describe the service provided are signed off by the consumer or representative or may be confirmed by the Personal Agent. A relative or friend who is a paid provider may not sign off on his or her own timesheets or invoices showing the hours worked. All family members, neighbors, friends and other persons involved in the participant's life are assessed as natural supports before any paid supports are included in the Individual Support Plan. Payment can only be made for needs unmet by natural supports.

- **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

There is no specific open or closed period for provider enrollments. Any individual or agency can enroll to become a provider of waivered services at any time, providing that they can meet all the necessary and required actions as stipulated by Oregon Revised Statutes, Oregon Secretary of State, Oregon Administrative Rules, and/or other criteria required to become a provider for the type of Medicaid services they wish to provide. This applies to individual providers as well as agency providers.

Potential individual providers may approach any brokerage to request a review of their qualifications in order to become available to provide waiver services to waiver participants. Waiver participants may request that potential individual providers, chosen by themselves or their representative to provide waiver service, be vetted for qualifications.

Agencies desiring to provide waiver services can request an application from SPD to provide waiver services. On average, it takes the SPD Licensing Unit 30 days or less to issue a certification to a brand new provider when the provider has submitted all the relevant information and has met all the requirements of a new provider as specified in Administrative Rules.

When a provider is certified by SPD, the certification review process verifies training of a provider's employees. In services where individual providers are used, it is up to the individual or their employer agent to verify that their employee-provider has the training necessary to do their job tasks. Individual brokerages may assist those employers to verify. Any qualified individual or agency provider is available to be selected by a waiver participant to provide waiver services.

DHS offers guidance and instruction to potential providers on its website. The website address is http://www.oregon.gov/DHS/spd/provtools/index.shtml. Potential providers and current providers may review rate setting manuals, worker guides, rules and regulations, and various other resources and tools.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of providers identified in a service plan that require licensure and/or certification under Oregon Administrative Rule. Numerator: Providers that prior to providing waiver services initially met and continue to meet qualification requirements. Denominator: All providers providing waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of non-licensed or non-certified providers as identified in service plan who adhere to OAR qualification requirements. Numerator: Non-licensed or non-certified providers identified in service plan who adhere to OAR qualification requirements. Denominator: All waiver service providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of providers who are trained per Oregon Administrative Rules and the approved waiver. - Numerator: Providers that are trained per Oregon Administrative Rules and the approved waiver. - Denominator: All Providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft

		calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State Support Services staff learn of problems from multiple sources, including file reviews, participant interviews, observation in the participant's home, and reports from families, community partners, and other professionals. Remediation requirements are identified via ongoing quality assurance activities (field reviews, certification reviews, ongoing data analysis) or addressed as needed based on specific situational events e.g. grievances, abuse investigations, etc.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

a) This upper limit applies to the total cost of all waiver-funded home and community-based services available to each individual served under this waiver each plan year. The currently approved level is $21,562 per year unless otherwise authorized in accordance with state administrative rules and policy.
b) The new limit reflects the amount above which SPD may enroll individuals in the Comprehensive Services Waiver (#0117.90.R3), unless authorized in accordance with state administrative rule and policy.
c) SPD adjusts this limit periodically as Legislatively authorized.
d) If participant needs cannot be met under this waiver, SPD will transfer the participant to the comprehensive services waiver or other appropriate setting.
e) Same as (d).
f) Participants will be notified when their total annual plan of care is likely to exceed the waiver limit, and informed of the options for service that the participant has under the comprehensive services waiver.
Within the Individual Cost Limit, there are several benefit levels for which a person may be eligible. All participants are eligible for the same Basic Benefit. The Basic Benefit may be supplemented by an ADL Supplement and/or a Mid Level Basic or a Full Basic Supplement.
· Documentation of ADL needs beyond what can be supported by the basic benefit establishes eligibility for the ADL Supplement.
· The Basic Supplement Criteria Inventory, a copy of which is published to the web on the Department's web site, identifies support-related circumstances of participants and generates a score based on those circumstances. The Inventory determines if the individual is eligible for the Mid-Range Supplement allocation or Full Supplement to Base allocation or neither. Those who qualify are individuals with extraordinary long-term needs.
Within the individual's benefit level the individual establishes an annual plan that may have a cost below or up to the total benefit level that individual is eligible to receive, not to exceed the Individual Cost Limit identified in Appendix B-2.a.
Individual budgets for participants are not open for public inspection. However, the process, tools, and guidelines for determining individual budgets are subject to this public review. The cornerstone elements to the development of individual budgets are the:
1. list/description of allowable expenditure under the waiver program;
2. rate guidelines for purchase of the allowable services;
3. a tool for determining access to benefit limits above the base benefit; and
4. the Department's administrative rules governing program implementation, which covers the process for individual support plan and budget development.
These tools and documents are subject to ongoing review and discussion by the broad based stakeholder group that oversees the implementation of Adult Support Services for individuals with developmental disabilities. This group meets every other month. Additionally, these tools are available to the public via the Departments web page. There is a process in place where people viewing the web page can make inquiries directly to the Department. These inquiries are flagged by department staff for a response.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Support Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker.**
Specify qualifications:

☑ **Other**
Specify the individuals and their qualifications:

Personal Agents perform the duties of "Case Managers." Their qualifications are defined in Appendix C-1/C-3, under the service "Support Services Brokerage Operations (Organized Health Care Delivery System)." The term Personal Agent is synonymous with Case Manager.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The following specific conditions are outlined in Oregon Administrative Rule:

When a brokerage is part of, or otherwise directly affiliated with, an entity that also provides services an individual may purchase with private or support services funds, brokerage staff must not refer, recommend or otherwise support the individual to utilize this entity to provide services unless:
~ The brokerage conducts a review of provider options that demonstrates that the entity's services will be cost-effective and best-suited to provide those services determined by the individual to be the most effective and desirable for meeting needs and circumstances represented in the ISP; and
~ The entity is freely selected by the individual and is the clear choice by the individual among all available alternatives.
The brokerage must develop and implement a policy that addresses individual selection of an entity of which the brokerage is a part or otherwise directly affiliated to provide services purchased with private or support services funds. This policy must address, at minimum:
~ Disclosure of the relationship between the brokerage and the potential provider;
~ Provision of information about all other potential providers to the individual without bias;
~ A process for arriving at the option for selecting the provider;
~ Verification of the fact that the providers were freely chosen among all alternatives;
~ Collection and review of data on services, purchased by an individual enrolled in the brokerage, by an entity of which the brokerage is a part or otherwise directly affiliated; and
~ Training of Brokerage Personal Agents and individuals in issues related to selection of providers.
SPD verifies that the Brokerage policy is in place during its initial and certification reviews every 5 years.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Supports and information made available to the participant (and/or family or designated representative, as appropriate). The Oregon Administrative Rules require a Person Centered Planning process that includes a comprehensive assessment, The Customer Goal Survey. Further OAR requires:
The Support Services Brokerage must make accurate, up-to-date information about the program available to individuals referred for services. This information must include:
~ A declaration of program philosophy;
~ A brief description of the services provided by the program, including typical timelines for activities;
~ A description of processes involved in using the services, including application and referral, assessment, planning, and evaluation;
~ A declaration of Support Service Brokerage employee responsibilities as mandatory abuse reporters;
~ A brief description of individual responsibilities for use of public funds;

(b) Participant’s authority to determine who is included in the process:
Plans must be signed by the individual except in cases where an individual without a designated representative has a physical or behavioral inability to sign and, in cases where there is a designated representative, the administrative rule requires that the individual be informed as completely as possible. OAR states: "Individual Support Plan (ISP)" means the written details of the supports, activities, costs, and resources required for an individual to achieve personal goals. This ISP is developed by the individual, the individual's Brokerage Personal Agent, the individual's designated representative (if any), and other persons who have been invited to participate by the individual or individual's designated representative. The ISP articulates decisions and agreements made through a person-centered process of planning and information gathering. The ISP is the individual's Plan of Care for Medicaid purposes. Brokerages are required to provide information, education and technical assistance for individuals with developmental disabilities in order to help facilitate effective plan implementation. This includes advising participants of their right to have the individuals of their choosing involved in the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including

securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Who develops the plan, who participates in the process, and what is the timing of the plan?

This ISP is developed by the individual, the individual's Brokerage Personal Agent, the individual's designated representative (if any), and other persons who have been invited to participate by the individual or individual's designated representative. The Brokerage Personal Agent (PA) writes the plan in accordance with OAR that requires a written plan:
ISP is developed by the individual, the individual's Brokerage Personal Agent, the individual's designated representative (if any), and other persons who have been invited to participate by the individual or individual's designated representative.
The Personal Agent must write an ISP. Unless circumstances allow exception under the rule, the ISP must be dated within 90 days of entry into Support Services Brokerage Services and at least annually thereafter. The plan or attached documents must include:

(A) The individual's name;

(B) A description of the supports required, including the reason the support is necessary;

(C) Projected dates of when specific supports are to begin and end;

(D) Projected costs, with sufficient detail to support estimates;

(E) A list of personal, community, and public resources that are available to the individual and how they will be applied to provide the required supports;

(F) The providers, or when the provider is unknown or is likely to change frequently, the type of provider (i.e. Independent Provider, Provider Organization, or General Business) of supports to be purchased with Support Services funds;

(G) Schedule of plan reviews; and

(H) The signature of the individual or the individual’s designated representative or documentation of the reason an individual who does not have a designated representative may be unable to sign the ISP. Acceptable reasons for an individual without a designated representative not to sign the ISP include physical or behavioral inability to sign the ISP. Unavailability of the individual is not an acceptable reason for the individual or designated representative not to sign the ISP.

(b) What types of assessments are conducted to support the service plan development process, including information about participant needs, preferences and goals, and health status?

The Customer Goal Survey includes sections on Home Life and Household needs, Medical/Dental and Health, Social and Leisure, Communication, Employment and education, Financial, Transportation. For each section, the survey seeks the preferences of both the individual and any others involved in planning. Each section then specifically asks about strengths, met and unmet needs, potential resources and risks in that life area.
Further, OAR requires:
The planning process must address basic health and safety needs and supports, including, but not limited to:
~ Identification of risks, including risk of serious neglect, intimidation, and exploitation;
~ Informed decisions by the individual or the individual's designated representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and
~ Education and support to recognize and report abuse.

c) How is the participant informed of services available under the waiver?

Brokerages and PAs are charged with addressing all identified needs regardless of whether the needed support is

available under the waiver or can be met using other available resources. The tool used to specifically inform individuals of services available under the waiver is the Roadmap to Support Services that is given to all individuals upon referral or entry to Support Services and is also available on the internet at: http://ocdd.org/index.php/ocdd/publications/a_roadmap_to_support_services/

Per OAR, each Support Service Brokerage must provide or arrange for the following services as required to meet individual support needs:
~ Assistance for individuals to determine needs, plan supports in response to needs, and develop individualized budgets based on available resources;
~ Assistance for individuals to find and arrange the resources to provide planned supports;
~ Assistance with development and expansion of community resources required to meet the support needs of individuals served by the Brokerage;
~ Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct support providers;
~ Fiscal intermediary activities in the receipt and accounting of Support Service funds on behalf of an individual in addition to making payment with the authorization of the individual;
~ Employer-related supports, assisting individuals to fulfill roles and obligations as employers of support staff when plans call for such arrangements; and
~ Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

(d) How does the plan development process ensure that the service plan addresses participant goals, needs (including health care needs), and preferences?

The Customer Goal Survey includes sections on Home Life and Household needs, Medical/Dental and Health, Social and Leisure, Communication, Employment and education, Financial, Transportation. For each section, the survey seeks the preferences of both the individual and any others involved in planning. Each section then specifically asks about strengths, met and unmet needs, potential resources and risks in that life area.
Per OAR:
The planning process must address basic health and safety needs and supports, including, but not limited to:
~ Identification of risks, including risk of serious neglect, intimidation, and exploitation:
~ Informed decisions by the individual or the individual's designated representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and
~ Education and support to recognize and report abuse.

When applicable, a Nursing Care Plan or a Plan of Care Crisis Addendum is attached to the individual plan of care.

(e) How are waiver and other services coordinated?

Brokerage Personal Agents (PA) coordinate all services by assisting the individual to access community and personal resources prior to accessing waiver services. Plan forms include sections to identify other resources available to meet needs.
Per OAR:
Approved written plan required. A Support Services Brokerage may use support services funds to assist individuals to purchase supports in accordance with an ISP that:
~ Identifies supports that are necessary for an individual to live in his or her own home or in the family home;
~ Specifies cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal resources available to the eligible individual;
~ Projects the amount of support services funds, if any, that may be required to purchase the remainder of necessary supports and that are within the Basic Benefit limits, unless authorized for supplement to the Basic Benefit according to OAR.

(f) How does the plan development process provide for the assignment of responsibilities to implement and monitor the plan?

The PA is assigned the responsibility to develop, approve, implement and monitor the plan. OARs require a projection of service dates, projected costs and plan reviews. Plan monitoring is addressed in OAR:
The PA will conduct and document reviews of plans and resources with the individual and the individual's designated representative as follows:
*~ At least annually and as major activities or purchases are completed:

(A) Review and reconcile receipts and records of purchased supports authorized by the ISP;
(B) Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;
(C) Record final Support Services fund costs;
(D) Note effectiveness of purchases based on Personal Agent observation as well as individual satisfaction; and
(E) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.*

(g) How and when is the plan updated, including when the participant's needs change?

The plan is updated at least annually and is also revised whenever preferences, needs or applicable supports change. Circumstances for revision include, per OAR: Significant changes in the ISP that include, but are not limited to, changes in the types of support purchased with support services funds and changes in supports that will cause total Plan Year expenses to exceed original estimates by more than 10%, but which do not include changes in the providers chosen to provide direct assistance to the individual.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Customer Goal Survey includes sections on Home Life and Household needs, Medical/Dental and Health, Social and Leisure, Communication, Employment and education, Financial, Transportation. For each section, the survey seeks the preferences of both the individual and any others involved in planning. Each section then specifically asks about strengths, met and unmet needs, potential resources and risks in that life area.
Per OAR:
The planning process must address basic health and safety needs and supports, including, but not limited to:
~ Identification of risks, including risk of serious neglect, intimidation, and exploitation;
~ Informed decisions by the individual or the individual's designated representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and
~ Education and support to recognize and report abuse.
Risks and/or information identified in the Customer Goal Survey are incorporated and addressed in the ISP, including an individual's back-up plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Once a waiver service has been determined to be necessary, Personal Agents ask if the individual has a potential provider or if the resources known to the Brokerage need to be accessed. Brokerages maintain listings of qualified providers that describe their service areas and other pertinent information.
Brokerages are required, per OAR, to inform individuals of the services provided by the Brokerage as well as the individualized services a customer may purchase from their individual budgets.
Oregon Administrative Rule states:
The Support Services Brokerage must make accurate, up-to-date information about the program available to individuals referred for services.
This information must include: An explanation of individual rights, including rights to:
~ Choose a Brokerage among Department contracted Brokerages who are currently serving fewer than the contracted number of individuals, in an individual's county of residence;
~ Choose a Personal Agent among those available in the selected Brokerage;
~ Select providers among those qualified, willing and available according to OAR to provide supports authorized through the ISP;
~ Direct the services of support providers; and

~ Raise and resolve concerns about Brokerage services, including specific rights to notification and hearing for Medicaid recipients according to OAR when services covered under Medicaid are denied, terminated, suspended, or reduced.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

As part of an ongoing quality assurance program, DHS Staff conduct field reviews and certification visits on a regular basis.
DHS staff reviews a statistically valid number of these service plans on no less than an annual basis and will provide technical assistance on an ongoing basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Support Services Brokerage.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

After Brokerages authorize plans of care, including back-up plans, Brokerage staff monitor implementation of the plans. Oregon Administrative Rules require periodic review of plan and resources. After Brokerages authorize plans of care, including back-up plans, Brokerage staff monitor implementation of the plans. Oregon Administrative Rules require periodic review of plan and resources. *The PA creates a customized monitoring schedule, conducts and documents reviews of plans and resources, and contacts individuals and/or the individual's designated

representative based upon the health and safety needs of the individual and other relevant factors, as agreed upon by the ISP team and identified in the plan of care. Direct contact with the individual (e.g. face-to-face or via telephone) occurs no less frequently than semi-annually and often more frequently per the customized monitoring schedule identified and documented in the individual's plan of care, as individual needs arise, and as activities or purchases are completed.

In addition to maintaining periodic direct contact, PAs are required to:

· Monitor and update the service plan when there are changes in the individual's needs;
· Review and reconcile receipts and records of purchased supports authorized by the ISP;
· Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;
· Record final Support Services fund costs;
· Note effectiveness of purchases based on PA observation as well as individual satisfaction; and
· Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.
· Advise individuals that, should issues arise, either the Brokerage or the individual and/or their representative may initiate and engage in unscheduled direct contact to assure issues can be addressed.
· Inform individuals that direct contact to assure health and safety and plan implementation is a requirement of waiver participation.*

Initial and ongoing assessment addresses many areas of possible support and individual support plans specify when an assessed need can be met by non-waiver services. These plan elements are monitored as other elements of the plan of care are monitored.

State staff conduct annual reviews of a statistically valid, random sample of all Plans of Care and specifically look at assessment of risk and safety factors. During the annual review State staff also review complaint and grievance logs at the Brokerages to determine whether concerns or issues of participants are addressed.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Brokerages may be stand alone organizations or may be part of a larger organization that also provide direct services. Oregon Administrative Rules are in place to provide safeguards.

The Brokerage must develop and implement a policy that addresses individual selection of an entity of which the Brokerage is a part or otherwise directly affiliated to provide services purchased with private or support services funds. This policy must address, at minimum:

~ Disclosure of the relationship between the Brokerage and the potential service provider;
~ Provision of information about all other potential service providers to the individual without bias;
~ A process for arriving at the option for selecting the service provider;
~ Verification of the fact that the service providers were freely chosen among all alternatives;
~ Collection and review of data on services, purchased by an individual enrolled in the Brokerage, by an entity of which the Brokerage is a part or otherwise directly affiliated; and
~ Training of Personal Agents and individuals in issues related to selection of service providers.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of participants whose service plans address assessed needs and personal goals per approved procedures. Numerator: Participants whose service plans address assessed needs and personal goals per approved procedures. Denominator: All waiver participant service plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
All particpants enrolled in Support Service Brokerage have a written and authorized service plan in accordance with Oregon Administrative Rules. Numerator: All participants enrolled in Support Service Brokerage with a written and authorized service plan in accordance with OAR. Denominator: All particpants service plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of service plans that are updated or revised annually. Numerator: Plans that are renewed within 365 days from the previous service plan. Denominator: All service plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine

		sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percentage of service plans that are revised when warranted by a change in needs. Numerator: Service plans that are revised when participant needs change. Denominator: All service plans.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of services delivered in accordance with what is specified in the service plan including the type, scope, duration and frequency. Numerator: Service plans for which services delivered are in accordance with the type, scope, duration and frequency specified in the plan. Denominator: All service plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Individuals choose among waiver services and qualified providers. Numerator: Participants who are offered choice of waiver services and qualified providers. Denominator: All waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Participants are offered the choice between institutional care and waiver services at initial enrollment into the waiver.

Performance Measure:
The percentage of participants who are offered the choice between waiver services and institutional care. Numerator: Waiver forms that indicate the participant was offered choice between waiver services and institutional care. Denominator: All Title XIX waiver forms.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Participants are offered the choice between institutional care and waiver services at initial enrollment into the waiver.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State Support Services Staff:
- completes site visits and file reviews annually;
- notifies Personal Agent of need (and timeline) for correction or further documentation using the Support Services Field Review checklist;
- conducts administrative followup to review remediation of problems; and
- provides retraining as necessary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Nature of opportunities for participant direction.
SPD provides opportunities for participants to exercise Employer Authority in Support Services. Participants may find their own candidates for employment, screen otherwise qualified candidates for ability to meet participant needs, hire, supervise, direct and discharge employees enrolled as qualified Providers. Participants establish work schedules and train employees in how they prefer to receive their services. Participants have the opportunity to exercise budget authority over their Individual Support Plan. SPD offers a basic benefit level to all participants as well as enhanced funding based on an assessment (Basic Supplement Criteria Inventory) for extraordinary care needs and particular caregiver circumstances. A comprehensive assessment (Customer Goal Survey) is completed for all participants. Within the participant's benefit level and based upon the necessary supports identified in assessments, the participant chooses what supports are desired. Within SPD rate guidelines, participants choose the rate of pay that providers receive.

(b) Process for accessing participant-directed services.
The Support Services Brokerage Personal Agent will discuss various waiver services options with every eligible individual/designated representative who chooses home and community-based services. When the preference is to receive waiver services at home, the Personal Agent will inform the individual/designated representative of the option to receive them from a domestic employee, independent contractor or provider organization.
Decision making authority for budgets is afforded to all participants and is built into the initial and ongoing Individual Support Plan development processes for Support Services.

(c) Entities involved in supporting participant direction and supports provided.
Information and assistance in support of participant direction:
· Support Services Brokerages maintain lists of providers who have met minimum qualifications as defined by Oregon Administrative Rules including a criminal history check conducted by DHS. Participants may also select their own providers who are referred to the Support Services Brokerage for qualification.
· Supports to the participant-employer include, but are not limited to: education about employer responsibilities; orientation to basic wage and hour issues; use of common employer-related tools such as job descriptions; and fiscal intermediary services.
· The participant-employer may also request further assistance of the Support Services Brokerage in working with providers.
· Most Support Services Brokerages have developed an orientation for Providers that describes roles and responsibilities of participants, Support Service Brokerages and Providers.
· The Support Services Personal Agent monitors the service plan, identifying risks and unmet needs and discussing options with individuals. At a minimum, reassessments of the functional abilities and unmet needs are completed once a year. Personal Agents are expected to identify and monitor more closely if the situation warrants, for example if the individual's health is particularly fragile, if there are provider issues, mental health concerns or protective service issues. The participant has the right to fire the provider at any time, for any reason.

· Support Services Brokerages assist the participant in creating an individualized budget based upon assessments of disability related needs, monitoring provider services and expenditures, reconciling expenditures against the individual budget and perform fiscal intermediary functions on behalf of the individual.

Financial management services:
· Support Services Brokerages issue payment to the qualified provider and handle tax and other employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on time sheets and invoices verifying the number of hours their employee worked, up to the maximum monthly hours authorized by the Individual Support Plan. Support Services Personal Agents may also verify services provided by direct or telephone contact with the participant
· Support Services Brokerages create job descriptions and service agreements based on the Individual Support Plan.
· Support Services brokerages may contract with an outside Fiscal intermediary (FI) or may perform the FI duties themselves. In either situation, the Brokerage is responsible for assuring financial management services are provided appropriately.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ◉ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

All waiver eligible individuals are informed of the variety of service options available to them including support services when they apply for home and community based services. Individual assistance is provided to the participant from their Support Services Brokerage as requested, including the provision of referrals to qualified providers that the participant can interview.
Oregon Administrative Rules require the provision of basic information by Support Services Brokerages to participants upon entry to Support Services including the right to choose a Support Services Brokerage within their geographic area, select among available Personal Agents, select among qualified providers, direct the services of providers and raise and resolve concerns about Brokerage services, including specific rights to notification and hearing for Medicaid recipients when services covered under Medicaid are denied, terminated, suspended, or reduced.
Per OAR, Brokerages must make accurate, up-to-date information about the program available to individuals referred for services. This information must include a brief description of individual responsibilities for the use of public funds and acknowledge this information by signing a document entitled ”Responsibility for Use of Public Funds”. Participants also acknowledge by signature that they may only use qualified providers and the limits of payment by the Support Services Brokerage based upon the individualized budget.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

The State does not provide for the direction of waiver services by a representative.

The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Participant approved friends or family members may supervise the completion of work provided by the provider. A relative or friend who is a paid provider may not sign off on his or her own timesheets or invoices showing the hours worked. All family members, neighbors, friends and other persons involved in

the participant's life are assessed as natural supports before any paid supports are included in the Individual Support Plan. Payment can only be made for needs unmet by natural supports.
Decision-making authority of a legal representative is consistent with State Law. For a non-legal representative, authority is limited to those of a common law employer when such a representative agrees to function in that capacity with the permission of the participant.
Oregon Administrative Rules prohibit services when there is sufficient evidence to believe that the individual or individual's designated representative has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to accept or delegate record keeping required to use Support Service Brokerage resources, or otherwise knowingly misused public funds associated with Brokerage services.
Based upon Oregon Administrative Rules, Support Services Brokerages may sanction any provider who has billed excessive or fraudulent charges or been convicted of fraud or has falsified required documentation. Sanctions imposed include withholding payment to the provider and temporarily or permanently disqualifying a provider from receiving Support Services funds.
Support Services Brokerages refer any cases involving allegations of financial exploitation to Protective Services and/or to the State of Oregon Medicaid Fraud Unit.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Environmental Accessibility Adaptations	☑	☑
Specialized Supports	☑	☑
Occupational Therapy Services	☑	☑
Chore Services	☑	☑
Supported Employment	☑	☑
Physical Therapy Services	☑	☑
Specialized Medical Equipment and Supplies	☑	☑
Personal Emergency Response Systems	☑	☑
Community Living and Inclusion Support	☑	☑
Respite	☑	☑
Speech, Hearing and Language Services	☑	☑
Non-Medical Transportation	☑	☑
Family Training	☑	☑
Special Diets	☑	☑
Emergent Services	☑	☑
Homemaker	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- (●) **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - [ ] **Governmental entities**
  - [x] **Private entities**

- ( ) **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- (●) **FMS are covered as the waiver service specified in Appendix C1/C3**

  The waiver service entitled:
  Support Services Brokerage Operations (Organized Health Care Delivery System)

- ( ) **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Support Services Brokerages or subcontracted fiscal intermediaries perform these services on behalf of the participant when the participant chooses Support Services:
· Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
· Support Services Brokerages facilitate completion of the INS I-9 form and the W-4 form for income tax withholding when a provider enrolls, along with other necessary application paperwork needed for provider enrollment.
· Support Services Brokerages process and pay all vendor and provider invoices.
· Support Services Brokerages maintain all employer and vendor related paperwork on behalf of the individual.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Support Services brokerages are compensated for operating costs based on a model budget developed specifically for Brokerage operations.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

SPD monitors and assesses the performance of FMS entities in the following ways:
· Annual Field Reviews conducted by SPD staff that review a statistically valid number of participant files including all fiscal and financial records. Expenditures are reviewed for being allowed under the waiver and Oregon Administrative rule, prior authorization in the Individual Support Plan and whether expenditures are accurately and appropriately assigned and reported.
· All expenditures are reported monthly to SPD from Support Services Brokerages via the CPMS (Client Process Monitoring System). SPD staff identifies inconsistencies based on waiver and Brokerage enrollment dates and expenditures that appear anomalous and follow up with SPD staff assigned to liaison with Support Services Brokerages to see correction of errors.
· The Department of Human Resources (DHS) Audit & Consulting Services Division conducts periodic reviews of programs administered by DHS, Support Service Brokerages were audited in 2004.
· Support Services Brokerages are required by contract to monitor services provided by Fiscal Intermediaries when these services are subcontracted out. In practice, this is done monthly as billings and tax withholding are reconciled against individual plan budgets.
· Support Services Brokerages are required by contract to comply with applicable audit requirements and responsibilities of the Office of Management and Budget (OMB) Circular A-133.
· Certification reviews every two years by state staff.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Brokerage Personal Agents conduct the following Targeted Case Management functions authorized under Oregon's Medicaid State Plan:
~Conduct comprehensive periodic reassessments of individual needs to determine the need for any medical, educational, social or other services. These reassessment activities include:
· taking client history;
· identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

~Develop (and periodic revision) a specific care plan that:
· is based on the information collected through the assessment and reassessment;
· specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
· includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's designated representative) and others to develop those goals; and
· identifies a course of action to respond to the assessed needs of the eligible individual.

~ Referrals and related activities:
· to help an eligible individual obtain needed services including activities that help link an individual with
· medical, social, educational providers or
· other programs and services that are capable of providing needed services by identifying potential providers, or by assisting with the qualification of providers identified by the recipient and by aiding in the coordination of services.

~Monitor and conduct follow-up activities:
· activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
· services are being furnished in accordance with the individual's care plan;
· services in the care plan are adequate; and
· there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers; and
· assist participant in assessing the effectiveness of the care plan.

Targeted Case Management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

There are no duplicate billings between Brokerage Operations and Targeted Case Management services.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations	☐
Specialized Supports	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Occupational Therapy Services	☐
Chore Services	☐
Support Services Brokerage Operations (Organized Health Care Delivery System)	☑
Supported Employment	☐
Physical Therapy Services	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems	☐
Community Living and Inclusion Support	☐
Respite	☐
Speech, Hearing and Language Services	☐
Non-Medical Transportation	☐
Family Training	☐
Special Diets	☐
Emergent Services	☐
Homemaker	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

As part of the waivered service and by Oregon Administrative Rule, Support Services Brokerages must provide or arrange for the following services:
· Assistance for individuals to determine needs, plan supports in response to needs, and develop individualized budgets based on available resources;
· Assistance for individuals to find and arrange the resources to provide planned supports;
· Assistance with development and expansion of community resources required to meet the support needs of individuals served by the Brokerage;
· Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct support providers;
· Fiscal intermediary activities in the receipt and accounting of Support Service funds on behalf of an individual in addition to making payment with the authorization of the individual;
· Employer-related supports, assisting individuals to fulfill roles and obligations as employers of support staff when plans call for such arrangements; and
· Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

Brokerages employ Personal Agents who, in addition to providing Medicaid State Plan Targeted Case Management services, may conduct the following activities (including, but not limited to):
· The provision of direct services, such as:
~ Money management, budgeting, etc.;
~ Counseling or advice about the risks associated with particular behavior or choices;
~ Supports provided while in the community with the individual;
~ Providing transportation;
~ Emergency back up support when a provider is not available;
~ Attend medical appointments; and

~ Assist with criminal/legal processes (support at court appearances, meet with Parole/Probation Officer).

· Problem Solving around (unless in the context of assessment related to plan development):
~ Personal Finances;
~ Issues relating to the FMS or employer agent;
~ Housing; and
~ Employment.

· Pre-enrollment activities; an individual must be enrolled in a brokerage to be able to provide case management services.
· Attendance at planning meeting for other types of service delivery (OVRS, IEP).
· General outreach, such as mass mailings and non-individualized information sharing.
· Clerical organization of customer files.
· Brokerage staff meetings.
· Training activities for Personal Agents.
· Communicate customer contact information changes to CDDP.
· Assist with provider recruitment/ community resource capacity development.
· Community education and outreach.
· Participate in Quality Assurance activities.
· Conduct training and provide supports to individuals regarding being an employer.

Support Service Brokerages must apply the principles of self-determination as defined in OAR to provision of services required in OAR.

There are no duplicate billings between Brokerage Operations and Targeted Case Management services.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- **No. Arrangements have not been made for independent advocacy.**
- **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants who voluntarily terminate Support Services are referred to the CDDP who act as gatekeeper to other available services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may exit Support Services and enter Comprehensive Services via the Crisis system when their needs are greater than can be met under Support Services. Transition into Comprehensive Services is governed by Oregon Administrative Rule.
Participants entering Crisis Services via Support Services have a "Support Service Brokerage Plan of Care Crisis Addendum" that serves as a bridge document if the participant exits Support Services and enters Comprehensive Services. This addendum covers areas including health and safety, medical, financial and behavioral. Additionally, Oregon Administrative Rule allows for a specific number of newly created Comprehensive placements outside of the Crisis system, these placements are available to participants in the Support Services Waiver.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		7042
Year 2		7742
Year 3		8442
Year 4		9142
Year 5		9842

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that

are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☑ **Recruit staff**
- ☑ **Refer staff to agency for hiring (co-employer)**
- ☐ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☑ **Verify staff qualifications**
- ☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☑ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☑ **Discharge staff from providing services (co-employer)**
- ☑ **Other**

Specify:

Discharge any provider of service or vendor of supplies.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☑ **Reallocate funds among services included in the budget**
- ☑ **Determine the amount paid for services within the State's established limits**
- ☑ **Substitute service providers**
- ☑ **Schedule the provision of services**
- ☑ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☑ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☑ **Identify service providers and refer for provider enrollment**

- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Support Services offers a basic benefit level to all participants. Benefit levels are enhanced by the addition of supplements to the Basic benefit. To receive a supplement the participant requests an assessment called the Basic Supplement Criteria Inventory (BSCI), administered by the Support Services Brokerage. The BSCI assesses a series of disability related support needs and caregiver circumstances and assigns scores to each section. Based upon the score received, the participant is granted access to one of two levels of enhanced funding. A further supplement is available to participants who have additional assistance needs with ADLs after development of their Individual Support Plan within the Basic Benefit. Within the assigned benefit level, and based upon a person centered Customer Goal Survey that assesses met and unmet needs as well as documenting existing natural supports, participants may choose which allowable goods and services are necessary to meet their needs. Costs are estimated based upon SPD published allowable rates and other limitations imposed by Oregon Administrative Rule. The tally of waiver goods and services included in the Individual Support Plan becomes the individualized budget for the participant.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Prior to waiver enrollment, Brokerages inform individuals of the budget limits for Support Services. Support Services Brokerages inform individuals of funding levels and criteria for enhanced funding upon entry. Oregon Administrative Rules (411-340-0130 (4) (a)) specify the process for requesting an enhanced benefit level for participants with extraordinary needs as such:
· Individual or designated representative requests in writing an assessment using DHS Form 0203, Basic Supplement Criteria Inventory (BSCI).
· Brokerage Personal Agents assist with this request as necessary.
· Brokerage Director or designee, who have received SPD approved training, administer the BSCI within 30 days of the request.
· The Brokerage Director or designee must score Basic Supplement Criteria according to written and verbal instruction received from the Department.
· The Brokerage Director or designee must send written notice of findings regarding eligibility for a supplement to the Basic Benefit to the individual and the individual's designated representative within 45 calendar days of the written request for a supplement. This notice must include the process for appeal.
· Annual ISP reviews for recipients of the supplement must include a review of circumstances and resources to confirm continued need.

Within a participant's assigned benefit level, changes to the individualized budget, once established, must be justified by a change in the participant's needs or existing paid and unpaid supports.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Oregon Administrative Rules require that Support Services Brokerages:
At least quarterly, review and reconcile receipts and records of purchased supports authorized by the ISP.
At least annually and as major activities or purchases are completed:
· Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;
· Record final Support Services fund costs;
· Note effectiveness of purchases based on Personal Agent observation as well as individual satisfaction;
· Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

SPD has implemented additional procedures to inform individuals of the right to request a Medicaid Fair Hearing, Administrative Review, and appeal rights on an annual basis. During the annual Individual Support Plan (ISP) meeting, the Brokerage Personal Agent responsible for assuring that the plan is developed informs the consumer and their guardian or designated representative of the consumer's Medicaid Fair Hearing, administrative review, and appeals rights. The consumer or his or her designated representative signs a document stating that they have been informed of the consumer's rights to a hearing, review, or appeal. Additionally, any time the consumer's benefits are denied, terminated or reduced they will be given notice and advised of their appeals rights.
Notification of Medicaid Fair Hearing rights:
~ At initial Level of Care (LOC)/waiver determination;
~ At the time a Notice of Planned Action is issued; and
~ Annual Documentation of:
- ~ Right to file a complaint
- ~ Grievance Process
- ~ Administrative Review process
- ~ Administrative Hearing process

Notifications of any planned adverse action or the opportunity for the individual to request a fair hearing are kept in the individiual's case file at the Brokerage.

Individual service recipients- and their designated representative- are provided timely written notice (Notice of Planned Action) of any planned change in services or benefits, including denial, closure or reduction. The notice includes the reason for DHS' decision, rules that support the decision and the individual/designated representative's right to due process through a fair hearing process.

When a Notice of Planned Action is issued, the notice includes a Notice of Hearing Rights explaining how to request the continuation of benefits. When the participant requests a Medicaid Fair Hearing on the form DHS 0443, they again receive a Notice of Hearing Rights explaining how to request the continuation of benefits.

Brokerage staff have been trained to provide participants with a Fact Sheet about Complaints, Fair Hearings and Administrative Reviews annually at the time of the ISP meeting. The Fact Sheet for Complaints, Grievances, Medicaid Fair Hearing and Administrative Review, which is presented to and discussed with the individual annually, explains what each of these is, when and how it would be used and how to initiate or request one. They are described as individual processes that can occur independently, not a linear process where the first three must be completed before the individual can request the fourth.

Individuals/designated representatives who want to contest the planned action complete submit a Fair Hearing Request to DHS. The Hearing Representatives are centralized and not part of any local office that determines benefits, services, or eligibility. The Hearing Representative reviews the notice sent to the participant to confirm adequacy and accuracy. Hearings are held by the Office of Administrative Hearings, which is independent from the Department of Human Services.

The Hearing Representative conducts an informal conference with the individual/designated representative to provide the individual/designated representative the opportunity to questions the planned action and to present additional information if applicable. After the informal conference, one of four actions occur:
~ The individual/designated representative voluntarily withdraws the request for hearing;
~ DHS withdraws the planned action;
~ The planned action is modified (in which case a new notice of planned action is sent to the individual/designated representative and the individual/designated representative once again has appeal rights); or
~ The case proceeds to hearing before an Administrative Law Judge.

If the individual/designated representative disagrees with the outcome of the Fair Hearing before the Administrative Law Judge, the individual/designated representative may appeal the final order by filing a petition in the Oregon Court of Appeals.

DHS, SPD maintains an automated database that tracks each phase of the hearings or review process and the outcome(s) for each individual/designated representative who requests an administrative hearing or administrative review.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates an additional dispute resolution process**

a. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

a. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Seniors and People with Disabilities.

b. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Oregon Administrative Rule governs Oregon's grievance processes. Grievances can be handled using a formal complaint process, through an administrative review process or by going directly to a Medicaid Fair Hearing (contested case), depending on the type of complaint.
An individual has the right to make a complaint anytime he or she is not satisfied with the services, supports or programs they are receiving or the people providing those services to them.
The Brokerage Personal Agent is responsible to inform the consumer and their guardian or designated representative of the consumer's rights regarding filing a complaint, requesting an administrative review, or requesting a Medicaid Fair Hearing during the annual Individual Support Plan (ISP) meeting. Brokerage staff provides participants with the Fact Sheet about Complaints, Fair Hearings and Administrative Reviews annually at the time of the ISP meeting.
The fact sheet explains:
~ What is a complaint and how to file a complaint;
~ What justifies an administrative review, the review process, and the timelines of the review; and
~ How an individual may request a Medicaid Fair Hearing, what occurs during the hearing process and the individual's rights during that process.

The consumer or his or her designated representative signs a document stating that they have been informed of the consumer's appeal rights through the complaint process, administrative review or Medicaid Fair Hearing.

The Fact Sheet includes a statement that directs an individual experiencing a denial, termination or suspension of Medicaid services to request a Medicaid Fair Hearing. Individuals will receive a notice when their Medicaid services are denied, suspended or terminated. The notice will direct the individual how to request a Medicaid Fair Hearing. Consumers will clearly be advised of their rights to go directly to this process. Instructions regarding the continuation of services while the Medicaid Fair Hearing process is pending are also provided. If the

individual/designated representative disagrees with the outcome of the Medicaid Fair Hearing, the individual/designated representative may file an appeal of the decision and final order in the Oregon Court of Appeals.

The administrative review process is requested when an individual is not satisfied with a proposed resolution to a complaint. This process is started at the Brokerage level and is used to resolve issues related to the provision of services not necessarily related to Medicaid Benefits issues. In the event the individual does not agree with the Brokerage Director's decision concerning his or her complaint, he or she may request a State Administrative Review.

For complaints that are not satisfactorily resolved at the provider or Brokerage level, the Brokerage will send a copy of the completed form via e-mail, first class mail, or fax to designated SPD staff. Upon SPD's receipt of the form, *the complaint shall be referred for Administrative Review either to Division Management or to an Administrative Review Committee according to Division policy.* The information is entered into a complaints tracking database and reviewed thereafter by the designated SPD staff.

In the event that an individual's complaint is with the Brokerage, the individual has the option of filing a complaint or request for an administrative review with the state. If the individual chooses to file the complaint with the Brokerage, the Brokerage Director has the responsibility of attempting to resolve the situation satisfactorily. If the situation cannot be satisfactorily resolved, the state may become involved in resolving the issue.

OAR describes, in detail, the processes and timelines involved in the grievance/complaint process. These timelines are related to Administrative Reviews and not to the Medicaid Fair Hearings process.
The timelines are briefly described below:
~ The Brokerage has 30 days to respond to a complaint.
~ The grievant has 15 days from the date of the complaint response to request an Administrative Review.
~ The Department has 45 days from the receipt of the request to convene the Administrative Review Committee and issue a Committee Report to the Administrator.
~ The Administrator has 10 days to issue a final decision to the complainant.

SPD has introduced a standardized form to be used in Brokerages for the purpose of recording consumer complaints. The form is titled "Developmental Disabilities Services Complaint Form". At a minimum, the form contains the nature of the complaint and the outcome or action the consumer would like to see taken regarding the complaint.

The above-mentioned form is electronically available to Brokerage staff through the DHS Forms Server.

With the use of the "Developmental Disabilities Services Complaint Form" and the complaint-tracking database within SPD, the State has the capability to consistently track all complaints that cannot be resolved at the local level and rise to the State Administrative Review level. The outcome of the State's Administrative Review is entered into the database and all information within the database is utilized to track whether the complaint process is timely, identify the development of any potential trends across the State, and in various other Quality Assurance/Quality Improvement activities.

The Governor's Advocacy Office (GAO) is another means by which grievances and complaints may come to SPD's attention. This office is at DHS in the Director's Office and provides a central point of access for anyone who has a problem with, or is seeking information about, the entire range of DHS services. If the GAO receives a complaint involving SPD services, GAO staff refers the complaint to SPD, where review and remediation occurs with the assistance of the appropriate local Brokerage.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Oregon Administrative Rule defines unusual incidents as those incidents involving death of an individual, injury or illness of an individual requiring inpatient or psychiatric hospitalization, or any incident requiring abuse investigation.
*Instances of abuse are defined in Oregon Revised Statutes and OARs as:
~ Death (caused by other than accidental or natural means, or occuring in unusual circumstances);
~ Abandonment;
~ Financial Exploitation;
~ Involuntary Seclusion/Restraint;
~ Neglect;
~ Physical Abuse;
~ Sexual Abuse; and
~ Verbal Abuse.

Any employee of a brokerage or provider organization is required to report incidents of abuse when the employee comes in contact with and has reasonable cause to believe that an individual has suffered abuse or that any person with whom the employee comes in contact, while acting in an official capacity, has abused the individual.
Notification of mandatory reporting status must be made at least annually to all employees on forms provided by DHS. All employees must be provided with a DHS-produced card regarding abuse reporting status and abuse reporting.
A written report that describes any unusual incident involving an individual and a brokerage or provider organization employee must be prepared at the time of the incident and placed in the individual's record.
Such description must include:
~ Conditions prior to or leading to the incident;
~ A description of the incident;
~ Staff response at the time; and
~ Administrative review and follow-up to be taken to prevent recurrence of the unusual incident.

Copies of all unusual incident reports involving abuse that occurs while an individual is receiving brokerage or provider organization services must be sent to the CDDP staff. Copies of reports of all unusual incidents that occur while the individual is receiving services from a provider organization must be sent to the individual's brokerage within five working days of the incident.
The brokerage must immediately report to the CDDP, and the provider organization must report to the CDDP with notification to the brokerage, any incident or allegation of abuse falling within the scope of OAR. CDDPs treat any complaint or report alleging abuse as a report of a serious event and enter information about the event into the Serious Event Review Team (SERT) database within one working day of receipt of the report.
SPD maintains a secure, Web based system, Serious Event Review Team (SERT), for identification and follow up tracking of critical events.
The Serious Event Review Team (SERT) system provides:
~ Centralized reporting of serious events, including initial allegations of abuse;
~ A linked, computerized method in which to report serious events;
~ A standardized format for tracking and documenting CDDP, Brokerage and SPD actions and outcomes;
~ A longitudinal database from which to analyze state and local trends; and
~ Integration and review of serious events and significant licensing issues at both state and local levels.

When the CDDP has initiated an abuse investigation, the CDDP must ensure that either the appropriate CDDP staff or the brokerage also immediately notify the individual's designated representative or conservator. The parent, next of kin or other significant person may also be notified unless the individual requests the parent, next of kin or other significant person not be notified about the abuse investigation or protective services, or unless notification has been

specifically prohibited by law.

Each individual participant and/or their family or their designated representative, as appropriate, receives information of their rights as a client, including their right to safe services, and how and where to report suspected abuse or neglect. This information is provided by Brokerage Personal Agents who also encourage participants, through phone and direct contact, to communicate concerns, complaints or reports of abuse at any time. Participants are also informed of their rights, including their right to safe services and to make complaints and report abuse, neglect or exploitation, at entry to a service and during the annual ISP process. This information comes from the Brokerage Personal Agents or from the provider organization or both. Individuals, their families, or designated representative are also informed that their Brokerage Personal Agents, local CDDP staff and their service providers are mandatory reporters of suspected abuse and neglect.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Each individual participant and/or their family or their designated representative, as appropriate, receives information of their rights as a client, including their right to safe services, and how and where to report suspected abuse or neglect. This information is provided by Brokerage Personal Agents who also encourage participants, through phone and direct contact, to communicate concerns, complaints or reports of abuse at any time. Participants are also informed of their rights, including their right to safe services and to make complaints and report abuse, neglect or exploitation, at entry to a service and during the annual ISP process. This information comes from the Brokerage Personal Agents or from the provider organization or both. Consumers, their representatives, or family are also advised upon initial entry into the Brokerage and at annual ISP meetings of DHS' extensive Web and printed materials on how to report abuse and neglect of adults. Individuals, their families, or designated representative are also informed that their Brokerage Personal Agents, local CDDP staff and their service providers are mandatory reporters of suspected abuse and neglect.

DHS, Office of Investigations and Training (OIT) provides the following trainings to individuals and providers on an as needed basis:

1) Making Sense of the Abuse Reporting System: a three hour training for family members and consumers/customers, which providers also find of value. This training covers the abuse reporting statute and the OARs in depth, in common sense language designed for the target audience. It includes information on what to report, how to report, who to report to, and also includes OIT's toll free abuse reporting number for emergency after-hours access. This training is offered six to 10 times per year.

2) Could This Happen in Your Program?: Designed for providers of services to individuals with mental illness and/or developmental disabilities and uses case studies to surface the very real issue of appropriate 911 and emergency services referral and contact situations. The workshop also covers reportable abuse incidents which fit statute and OAR definition and goes further to discuss protocols and policies organizations might have in place-or need to develop- both situations that may not rise to the threshold of reportable abuse. This training is conducted 2 to 3 times per year.

3) The Choices We Make: This is a new video and desktop training package which contains two DVDs and a participant workbook. The target audience is community providers and partners, though family members and self advocates have found it helpful. The DVDs cover all of the abuse reporting statute and OAR information and offer 8 individual vignettes, filmed across the state using real providers and consumers as the actors, illustrating different possible incidents which may or may not rise to the reportable threshold. The workbook is designed to be self paced and is a supplement to the film, allowing for mangers and/or individuals to test their understanding of the material covered in the film. More than 2000 copies of this training material have been sent out. Copies were mailed to every SPD and Addictions and Mental Health Division (AMHD) licensed adult foster home, every provider organization's central office, and every Community Mental Health Program and CDDP. These entities show the materials as they deem fit but OIT has received very positive feedback that entities both like it and use it regularly. The materials are also used to supplement some mandatory abuse trainings for providers approximately 10 to 20 times per year.

4) Provide technical assistance and presentations on abuse prevention and reporting by request, and as schedule permits, to community partners, self advocacy groups, survivor groups, and providers.

In all of these trainings and presentations, the OIT toll free abuse reporting number is presented and the connections made between the participants and the appropriate local county reporting entity the individual would usually use as their first contact.

Protective services are those steps taken to prevent abuse or neglect and to keep people safe. Protective services are provided for all adults and children with developmental disabilities who are eligible for or are receiving DD services in the community. Individuals who are able to make their own decisions may refuse to accept offered services.

Protective services can include:
~ Assisting in or arranging appropriate services and alternative living arrangements;
~ Assisting in or arranging the medical, legal or other necessary services to prevent further abuse;
~ Providing advocacy to assure the individual's rights and entitlements are protected;
~ Arranging for the immediate protection of the individual;
~ Contacting the adult to assess his or her ability to protect his or her own interest and give informed consent;
~ Determining the ability of the adult to understand the nature of the protective service and his or her willingness to accept services; and
~ Coordinating evaluations to determine or verify the individual's physical and mental status, if necessary;
~ Coordinating with the protective service investigation entities (law enforcement, DHS Office of Investigation and Training) to assure a full complete investigation, and appropriate correction and follow-up plan.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Oregon’s providers of developmental disability services have long been required to report unusual incidents involving service recipients. Copies of all unusual incident reports involving abuse that occurs while an individual is receiving brokerage or provider organization services must be sent to the appropriate CDDP staff. Copies of reports of all unusual incidents that occur while the individual is receiving services from a provider organization must be sent to the individual's brokerage within five working days of the incident.
The brokerage must immediately report to the CDDP, and the provider organization must report to the CDDP with notification to the brokerage, any incident or allegation of abuse falling within the scope of OAR. CDDPs treat any complaint or report alleging abuse as a report of a serious event and enter information about the event into the Serious Event Review Team (SERT) database within one working day of receipt of the report. Brokerages also receive, review, and follow up reports of incidents involving individuals with developmental disabilities per Oregon Administrative Rule requirements.
CDDPs are required to enter statutorily defined instances of abuse into the SERT database within 1 calendar day of notification. CDDPs are required to complete their County Review process and Abuse Investigations within 45 from date of entry of incident into SERT database (barring any delays by law enforcement or other investigative agency). Local CDDP SERT teams convene at least quarterly to develop local and system-wide responses and preventive actions to address system deficiencies or emerging concerns that could potentially harm individuals served.
Abuse related investigations are generally conducted by CDDP Abuse Investigators. However, Office of Investigation and Training (OIT) may conduct abuse investigations in the event of a conflict of interest at the CDDP or when asked for assistance by the CDDP.
Law Enforcement Agencies (LEA) or Local District Attorneys (DA) are responsible for investigating criminal allegations. These entities do not have access to the SERT database. CDDP SERT entries note referrals for investigation in cases involving individuals with DD where there is reason to suspect a crime or incident of abuse has occurred. Local LEA and DA may collaborate with the local CDDP, Brokerage or OIT in response to/investigation of serious events where there is reason to suspect a crime has occurred and may inform the CDDP or Brokerage about the outcome of the criminal investigations. However, they are not required to release any information on the outcomes of investigations to DHS.
Per OAR, upon completion of the abuse investigation, and within 45 calendar days of the date of a report alleging abuse, the community programs will prepare an abuse investigation and protective services report which includes:
(a) A statement of the alleged incident being investigated, including the date(s), location(s) and time(s);
(b) An outline of steps taken in the investigation, a list of all witnesses interviewed and a summary of the information provided by each witness;
(c) A summary of findings and conclusion concerning the allegation of abuse;
(d) A specific finding of substantiated, inconclusive or not substantiated;
(e) A list of protective services provided to the adult to the date of the abuse investigation and protective services report;

(f) A plan of action necessary to prevent further abuse of the adult;
(g) Any additional corrective action required by the community program and deadlines for the completion of these action;
(h) A list of any notices made to licensing or certifying agencies;
(i) The name and title of the person completing the report; and
(j) The date it is written.
Abuse investigation and protective services report formats will be provided by the Department.
A copy of the abuse investigation and protective services report will be provided to the Department within five working days of the report's completion.
Portions of the abuse investigation and protective services report and underlying investigatory documents are confidential and not available for public inspection. Pursuant to ORS, names of persons who make reports of abuse, witnesses, and the alleged abuse victim are confidential and shall not be available for public inspection.
Investigatory documents, including portions of the abuse investigation and protective services report that contains "Individually identifiable health information", as that term is defined under ORS and 45 CFR160.103, are confidential under HIPAA privacy rules, 45 CFR Part 160 and 164, and ORS 192.520 and 179.505 to 509.
Notwithstanding the above-listed information, the Department will make the confidential information, including any photographs, available, if appropriate, to any law enforcement agency, to any public agency that licenses or certifies facilities or licenses or certifies the persons practicing therein, and to any public agency providing protective services for the adult. The Department will also make the protective services report and underlying investigatory materials available to any private agency providing protective services for the adult and to the protection and advocacy system designated pursuant to ORS.
When the report is completed, a redacted version of the abuse investigation report not containing any confidential information, the disclosure of which would be prohibited by state or federal law, will be available for public inspection.
When the abuse investigation is conducted and protective services report is completed by a CDDP, as the Department's designee, the protective services investigation may be disclosed pursuant to OAR either by the CDDP or the Department.
Currently, DHS, CDDPs and Brokerages do not have a formal process by which they notify individuals of the outcome of their own abuse investigations. If protective services are necessary as a result of an allegation, they are provided as needed.
Individuals are generally made aware of the status of their investigations during the course of protective service actions. Individuals have the right to and may request of the CDDP or Brokerage at any time the outcome of his or her investigation. All individuals receiving services under the Support Services Waiver will be informed by the Personal Agent when an abuse allegation resulted in a substantiated outcome. The result will take place, at a minimum, during the individual ISP or during another regularly scheduled visit.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oregon Department of Human Services, Seniors and People with Disabilities is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants.
Local CDDP staff and State Quality Assurance staff review critical incidents and related follow-up data on a regularly scheduled basis to identify emerging trends.
Local CDDP SERT teams convene at least quarterly to develop local and system-wide responses and preventive actions to address system deficiencies or emerging concerns that could potentially harm individuals served.
DHS, SPD, Office of Federal Reporting and Financial Eligibility, Quality Assurance staff facilitates regularly scheduled meetings to evaluate and identify issues relating to the health and safety of waiver participants. The Developmental Disabilities Waiver Oversight group (DDWO) is comprised of Department staff. This group currently includes SPD Administration, Licensing and Quality of Care staff, Office of Developmental Disabilities Services (ODDS) Regional Coordinators, ODDS Support Specialists, ODDS Program Specialists, Health Support Unit staff, Quality Assurance staff, OIT staff, and State Operated Community Program (SOCP) staff. The focus of this group is to evaluate data extracted from SERT, discuss concerns expressed and information provided by the CDDPs, Brokerages, Advocacy Groups, and State Quality Assurance Committee to identify possible statewide or local trends relating to the health and safety of waiver participants. Findings from these analyses may trigger a policy or procedure change.
A second, smaller group, the Developmental Disabilities Waiver Oversight Workgroup (DDWOW), is tasked with pulling various types of data from SERT and reviewing it to make recommendations of action to the DDWO.
The DDWO and DDWOW share a symbiotic relationship. Trends and issues may be identified by either group and both groups work in tandem to address any trends or issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

  The individuals enrolled in the Support Services Waiver are served in their own or family home. Their Plans of Care do not include the use of restraints or seclusion. Brokerage Personal Agents who oversee the Plans of Care and the services delivered in the home report any use of restraints or seclusion to the CDDP, who in turn enters the information into the SERT system.
  If harm is caused or there is a threat of harm, a report of abuse may be made to local law enforcement. Personal Agents, through regular contact by phone, e-mail and visit with the individual, families and providers, perform continual service monitoring and guidance to individuals and families about the individual's care and safety needs and appropriate service provision.

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  The individuals enrolled in the Support Services Waiver are served in their own or family home. Their Plans of Care do not include the use of restraints or seclusion. Brokerage Personal Agents who oversee the Plans of Care and the services delivered in the home report any use of restraints or seclusion to the CDDP, who in turn enters the information into the SERT system.
  If harm is caused or there is a threat of harm, a report of abuse may be made to local law enforcement. Personal Agents, through regular contact by phone, e-mail and visit with the individual, families and providers, perform continual service monitoring and guidance to individuals and families about the individual's care and safety needs and appropriate service provision.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
○ **Yes. This Appendix applies** *(complete the remaining items)*

a. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

i. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of participants who are victims of substantiated abuse, neglect or exploitation. Numerator: Participants who are victims of substantiated abuse, neglect or exploitation. Denominator: All participants of this waiver.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Identified individual risk and safety considerations are addressed taking into account the individual's informed and expressed choices. Numerator: Identified risks and safety considerations addressed taking into account the individual's informed and expressed choices. Denominator: All identified risks and safety considerations.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percentage of providers identified in a service plan that require licensure and/or certification under Oregon Administrative Rule. Numerator: Providers that prior to providing waiver services initially met and continue to meet qualification requirements. Denominator: All providers providing waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percentage of non-licensed or non-certified providers as identified in service plan who adhere to OAR qualification requirements. Numerator: Non-licensed or non-

certified providers identified in service plan who adhere to OAR qualification requirements. Denominator: All waiver service providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percentage of providers who are trained per Oregon Administrative Rules and the approved waiver. - Numerator: Providers that are trained per Oregon Administrative Rules and the approved waiver. - Denominator: All Providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Incidents that involve possible abuse are entered into the SERT system and investigated by the Community Developmental Disability Program. The Abuse Investigation and Protective Service Report are submitted to the Office of Investigation and Training (OIT). Support Service Program Analysts meet quarterly with staff to discuss data, analyze trends and to identify training needs. Incidents that do not meet the criteria of abuse but do meet the criteria of a serious incident, are entered into a Support Service data base. Support Service Program Analysts review the data for problem areas and trends. Abuse Investigations and incident reports are part of the annual Field Review.

Reports of suspected fraud are made by Brokerage staff directly to the DHS Medicaid Fraud Unit or the DHS Provider Fraud Unit, depending on the allegation. Any concerned party may report fraud to SPD or to the DHS Fraud Units. Investigations occur by DHS staff employed in one of those Units. An outcome of an investigation may result in the revocation of provider status. There are no limits on the time frames for fraud investigations.

Support Service Program Analysts participate on the SPD statewide SERT and Waiver Oversight groups to determine if emerging trends and potential responses overlap with other SPD service elements, geographic indicators or training initiatives in order to assure a coordinated agency response.

State Support Services Staff completes site visits and file reviews annually, including Incident Reports and the associated follow up activities undertaken by the brokerage and:
- notifies Brokerages of need (and timeline) for correction or further documentation using the Support Services Field Review checklist;
- conducts administrative follow up to review remediation of problems; and
- provides retraining as necessary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

SPD staff are responsible for effectively utilizing the discovery and remediation information identified during the course of each year. Quality assurance and waiver staff from SPD's Office of Federal Resource and Financial Eligibility work with staff to collect and analyze data and recommend programmatic changes for quality improvement.

Management or delegated staff attend and participate in regularly scheduled Developmental Disabilities Waiver Oversight (WO) meetings. These meetings are attended by DHS and SPD staff from a range of program and service areas including Office of Licensing and Quality of Care, Office of Investigations and Training (OIT), County Relations, Adult Support Services, State Operated Community Programs and SPD Management. This group presents, compares, and discusses issues and trends in data reports across all waivers from a range of sources including OIT, Licensing, file and program reviews and surveys, State program QA meeting notes and summaries. Information and resources from other state programs and external sources is frequently shared and discussed.

Support Service staff attend and participate in quarterly Developmental Disabilities Quality Assurance Committee (DD-QAC) meetings. The DD-QAC is comprised of representatives from State program staff, SPD management, Provider organizations, Support Service Brokerages, County DD staff, Advocacy and Self -advocacy groups and the Oregon Technical Assistance Corporation. State program staff present regular Waiver program updates including enrollment data across all services and waivers, QA activities and report on benchmarks and progress towards QA and QI goals. DD-QAC participants advise State program staff on priorities and activities to further QA and QI goals.

Support Service staff utilize reports from file reviews, enrollment data, and complaint log data to assess progress toward quality improvement goals and to establish new goals. They review the Brokerage Consumer Satisfaction Survey data and the In-Home Services Consumer Satisfaction Survey data. They collaborate with the Staley Implementation Group to incorporate consumer feedback into long range service planning and program design.

In addition to the meetings noted above, staff receive and provide ongoing input and feedback in settings including weekly Developmental Disabilities Strategy meetings, weekly policy meetings, Administrative Rule workgroups and issue-specific cross-waiver workgroups.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

SPD staff administer all services delivered through this waiver.
SPD staff use findings from discovery and remediation activities related to the six assurances and other parameters to establish priorities for system improvement and evaluate the effectiveness of those improvements.
The staff seek input from participants, families, providers, and other interested parties/groups to find ways to deliver waiver services more effectively and efficiently and move the participant toward outcomes stated in approved plans of care.
SPD staff collect QI information from the performance measures related to the six assurances and other topic areas. They work with participants, families, providers, and others to address both concerns raised and improvement opportunities identified.
SPD has created a Quality Management Strategy (QMS) detailed in a matrix available at http://www.oregon.gov/DHS/spd/qa/app_h_qa.pdf that details activities, roles, responsibilities and timelines for Quality Improvement.
This QMS encompasses waivers serving three populations: Seniors, adults with physical disabilities and individuals of any age with developmental disabilities. These waivers are:
· #0185.90.R2 for seniors, adults w/physical disabilities
· #0117.90.R3.01 for individuals with developmental disabilities (Comprehensive)
· #0375.01 Support services for adults with developmental disabilities
· #40193.90.02 Medically fragile children

· #0565.R00 Medically Involved Children's Waiver
· #40194.90.02 Children with severe behavioral challenges.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

SPD staff re-evaluate the QIS at least once during each waiver renewal period (or more as deemed appropriate) and update the QIS strategies employed.
The aforementioned WO and DD-QAC meetings are scheduled, staffed and facilitated by Quality Assurance and waiver staff from SPD's Office of Federal Resource and Financial Eligibility. These staff and Waiver program representatives bring forth issues, trends, priorities and concerns related to the QMS on both individual and multi-waiver levels. These groups evaluate and make recommendations to amend the QMS, OARs and policies as necessary to promote high quality services for waiver participants.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

SPD requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Service providers are required to permit authorized representatives of DHS to review these records for audit purposes. Providers are required to meet the requirements stated in Oregon Administrative Rule.

Audit staff from the Department of Human Services and the Secretary of State's Office review payment records of Department providers based on their applicable state statutes and administrative rules to ensure provider billing integrity. Staff from both agencies set audit priorities each year based upon assessed risk analysis. Audit methods include on-site review as well as independent data analysis. Audits are conducted on a schedule determined by DHS Auditing Staff and the Secretary of State's Office.

DHS auditors evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of State's Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. DHS determines the frequency of audits and also requests random records monthly.

A government body, an organization or an individual can trigger an audit. DHS auditors perform both desk reviews and on-site examinations of providers' records, facilities and operations, and other information Internal Programs. DHS auditors provide timely, accurate, independent and objective information about DHS operations and programs. An internal audit committee made up of representatives from each DHS administrative unit, including SPD, works closely with the Audit Unit to ensure comprehensive audit coverage. The committee approves an annual audit plan of risk-based and required cyclical audits, then meets every two months, updating the plan as needed based on special requests, investigations, legislative inquiry, or other administrative direction. Auditors have complete access to all necessary activities, records, property and employees. The auditors have no direct authority over activities being reviewed. They abide by the Institute of Internal Auditors' Code of Ethics and practices conform to the Standards for the Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors, the American Institute of CPA's (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA).DHS internal audits fall into two categories: classification and issue-specific.

Priority for audits is set by: Risk analysis, assessing the extent of fiscal, legal, and/or public policy impact for each potential audit subject, with those having the highest level of risk given top priority; and Database analysis, which determines the quantity, magnitude, degree of aberration, and inconsistencies that exist in current application of practices. Audit Unit staff and the audit committee use the audit process to assess functions and control systems and to make recommendations to DHS administration regarding issues such as: economical and efficient use of resources; progress meeting DHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contact terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.

Secretary of State Audits: The Audits Division is responsible for carrying out the duties of the Secretary of State's Office as the constitutional Auditor of Public Accounts. The Audits Division is the only independent auditing organization in the state with the authority to review programs of agencies in all three branches of state government and other organizations receiving state money. Authority for the responsibilities of the Audits Division is found in sections 297.00 through 297.990 of the Oregon Revised Statutes. Secretary of State auditors review the areas of finance, performance, information technology, and fraud and abuse. Frequency of SOS audits is based on risk assessment and on standards established by nationally-recognized entities including, but not limited to, the GAO and the National Association of State Auditors. Types of audits include: Financial and compliance audits of all components of state government and state-aided institutions. These audits determine whether a state agency has conducted its financial operations properly and has presented its financial statements in accordance with generally accepted accounting principles. Examinations of internal control structures and determine whether state agencies have complied with finance-related legal requirements. At the end of each engagement, the Division prepares an opinion regarding financial statements, reports significant finds, and recommends any necessary improvements.

Financial and compliance audits of the state's annual financial statements: This audit, the largest audit of public funds in the state and a major engagement of the Division, complies with the Single Audit Act of 1984 (PL 92-502) which requires such an audit annually as a condition of eligibility for Federal funds:
~ Performance audits of the operations and results of state programs determine whether the programs are conducted in an economical and efficient manner;
~ Special studies and investigations regarding misuse of state resources or inefficient management practices;
~ Requested audits or special studies for counties.

In accordance with statutory provisions and in cooperation with the State Board of Accountancy and the Oregon Society of Certified Public Accountants, the Division: develops the standards for conducting audits of all Oregon municipal corporations; prescribes, revises, and maintains minimum standards for audit reports; and reviews reports, certificates, and procedures for audits and reviews of corporations. The Division evaluates reports of audits or reviews of these municipal corporations and auditor's work papers for compliance with the standards. In addition to audit activities of the DHS Audit Unit and Secretary of State Audit Division.

The DHS Office of Payment Accuracy and Recovery receives reports of fraud in DHS programs and investigates allegations. The Office maintains a hotline for anyone to report fraud and will investigate allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of claims that are authorized and paid for in accordance with reimbursement specified in the approved waiver. Numerator: Reimbursements that are

authorized and paid for in accordance with the methods specified in the approved waiver. Denominator: All reimbursements.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = SPD uses the Raosoft calculator to determine sample sizes. Staff use: 10% margin of error, 90% confidence limits, and a response distribution of 50%.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State Support Services Staff completes site visits and file reviews annually which includes a review of timesheets and invoices submitted by providers for payment and:
- notifies Brokerages of need (and timeline) for correction or further documentation using the Support Services Field Review checklist;
- conducts administrative follow up to review remediation of problems; and
- provides retraining as necessary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates guidelines for all waiver services are established and published by the Department. Rate ranges are determined based on employment and market rates and type of provider. Rates must comply with Oregon's minimum wage standards.

Rate ranges are established by provider type for the following services:

· Homemaker;
· Respite;
· Supported Employment;
· Chore Services;
· Community Living and Inclusion Supports;
· Family Training;
· Non-Medical Transportation;
· Emergent Services; and
· Specialized Supports.

Costs of services are estimated based upon SPD published allowable rates and other limitations imposed by Oregon Administrative Rule. The total of waiver goods and services included in the Individual Support Plan becomes the individualized budget for the participant.

Support Services Brokerages may make exceptions to the established rate range based on complexity of the individual's needs in combination with the exceptional skills and training of a provider.

Rates for extended State plan services are established by the Department of Medical Assistance. These services are:

· Physical Therapy;
· Occupational Therapy; and
· Speech, Language and Hearing.

Rates for the following services are established using usual and customary local market rates:

· Environmental Accessibility Adaptations;
· Personal Emergency Response Systems;
· Specialized Medical Equipment and Supplies; and
· Special Diets.

The range for all rates is set exclusively by the State. Adherence to the ranges is assessed by reviewing a statistically valid number of rates paid to providers.

The rate guidelines are published to the web. The public may comment to the brokerage about rates or may contact the Department directly. Rates for services to be provided, as well as an estimate of the annual cost for each waiver service, are included on the Individual Support Plan, which serves to notify the participant of the cost of waiver services.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Payments will be made through Organized Health Care Delivery Systems (OHCDS). OHCDS's must be certified by the Department of Human Services as Support Service Brokerages who provide some direct services to consumers. The OHCDS will purchase services on behalf of waiver recipients. No qualified provider will be required to have an agreement with the OHCDS as a condition of service delivery; the provider may chose to have an agreement directly with the Department. OHCDS's will maintain provider agreements with other providers of service, copies of state licenses or certifications issued to providers, copies of applicable State issued professional licenses, and all other documentation of provider qualifications required in Appendix C "Provider Qualifications". The OHCDS is required to maintain a provider agreement with any qualified service provider selected by the individual to receive services. All persons or agencies which have a provider agreement with an OHCDS to provide waiver services must meet the same requirements and qualifications that apply to providers enrolled directly with the Medicaid agency. All OHCDS's must agree to bill the Medicaid agency no more than the amount allowable for the service provided. All agreements executed by the OHCDS, and all sub-agreements executed by its qualified providers, to provide waiver services, must meet the applicable requirements of 42 CFR 434.6 and 45 CFR Part 74, appendix G.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ◉ **No. State or local government agencies do not certify expenditures for waiver services.**
- ○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Direct payments of waivered services will be documented in the Client Process Monitoring System (CPMS). A billing form is completed for each individual receiving services. Brokerages have the option of using SPD's Reimbursement Type Services form or another SPD-approved form created by the Organized Health Care Delivery System (OHCDS) that contains the same information as SPD's form. The OHCDS (Support Services Brokerage) is responsible for the completion of the billing form and its submission to the Department. The billing form is used to document services provided and includes the name of the individual served, Medicaid ID number, type of service received, dates of service, and total amount billed for each service. This form is the documentation that will allow tracking of funds expended to service providers of individual clients.
The data from the billing form is maintained in a computerized database. This database documents the level of detail required to report the type of service received by waiver individuals. This database is separate from the main frame CPMS. Expenditures for each category of service in the waiver will be entered into this database. Each record in the database will contain the client identifiers, waiver eligibility, demographic information, type of service, the dates of service, and the cost of each service. A summarized record from this data base will be entered into the mainframe CPMS.
The database will produce reports that calculate the total cost and the number of individuals served in each service category. CPMS will then be used to verify that the total expenditures are accurate. This report will be reported annually on the CMS 372 Report.
Payment to the provider is not generated through the CPMS or the data base. At the time a request for payment is made, the completed CPMS form is used to initiate and justify the actual issuance of funds. A hard copy of the CPMS form is kept with the receipts. The Support Services Brokerage generates a check payment to the provider based on the services documented on the CPMS form. Services recorded on the form are based on the individual plan of care.
CPMS documents payments of both waivered and non-waivered services (state general funded services).
During SPD Staff's annual field reviews, a statistically valid, random sample of case files are reviewed to ensure that services identified on an individual's plan of care have been provided and billed appropriately.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

The Department issues yearly allocations to each Support Services Brokerage for the cost of direct services, based on projections of monthly expenditures, using the state's General Fund money. Each Brokerage is required to submit expenditure reports, by client, to the Department detailing how the allocations were expended. The Department issues monthly and annual reports to each Brokerage along with a biennial settlement report. Every quarter SPD reviews what the Brokerages have reported as their actual expenses in Adult Support Services and adjust the contract if they are a certain percent under or over-expended in their allocations. The Department's settlement report compares the amount of the allocation for services issued to each Brokerage against the expenditure reports submitted by the Brokerage. If the Brokerage has not expended the entire allocation the settlement report provides an amount owed by the Brokerage to the Department. A Brokerage may rebut the settlement report and provide supporting information. A designated timeframe for

response is included in the settlement report. Department staff review each Brokerage's rebuttal and supporting documentation, if any. If the rebuttal and supporting documentation are valid the Department will recalculate the settlement and issue a response to the Brokerage that includes the new settlement amount. In the event that a Brokerage still doesn't agree with the settlement report the Brokerage may file an informal appeal. This process currently is managed through both Rbase and Client Process Monitoring System (CPMS).
Payments of waivered services are documented in the Client Process Monitoring System (CPMS) through the use of expenditure report forms. The Organized Health Care Delivery System (Support Services Brokerage) or their appointed Fiscal Intermediary, generates a check payment to the actual service provider, based upon the service delivery documented in receipts, bills or time cards. At the time a request for payment is made by the service provider, the Brokerage first verifies the service delivery, and then authorizes the payment to the service provider.
After the payment is made, a CPMS form is completed by the Brokerage or the appointed Fiscal Intermediary, and submitted to the Department as a record of the actual issuance of funds from their allocation. A hard copy of the CPMS form is kept with the receipts. Service payments documented on the CPMS expenditure report forms are based on the individual plan of care.
CPMS reports that give the breakdown for Title XIX are generated two to three months after the initial general fund payment is made, depending on the type of service element. Because of this lag, in the month the payment is made, the state estimates what the Federal Financial Participation amount will be. This is DHS' Cash Management Improvement Act (CMIA) estimate. Upon receipt of the CPMS reports, the entries are made into SFMA as reported in CPMS. This entry credits the general fund advance payment and debits the appropriate fund source (Title XIX, Title XIX match and general fund unwaivered services).
Brokerage Operations is paid through the Express Payment and Reporting System (eXPRS) payment system. The eXPRS payment system is an electronic, web-based system that manages all aspects of client enrollment, rate authorization, provider claims and billing, and subsequent reports related to those functions for services paid through eXPRS.
Direct payments to providers of waiver services, upon the provider's request, will be made using the following method:
A provider who does not voluntarily agree to contract with a designated OHCDS may execute a provider agreement with DHS and, based upon the services provided, would be enrolled in a Medicaid-approved payment system.

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The State contracts directly with the Organized Health Care Delivery System (OHCDS, Support Services Brokerage). The Support Services Brokerage has agreements with providers who furnish other services to waiver individuals, and makes payment to providers of these services.
The Support Services Brokerage may contract with an external organization or entity as a financial intermediary to pay providers. This is part of the OHCDS's responsibility to pay providers and is considered part of the OHCDS's service.
Direct payments will be made using the following method:
The State will establish provider agreements and make payment to any qualified provider who does not choose to contract with an OHCDS.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ● **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS:
Support Service Brokerages are the entities designated by the state as OHCDS. Support Services Brokerages provide some direct services to consumers. This designation doesn't alter any described assurance or process described in other parts of this application.
Support Services Brokerages meet the designation of an OHCDS because:
- Brokerages provide at least one Medicaid service using its own employees;
- Brokerages execute provider agreements with providers of waiver services;
- Brokerages receive payment directly from DHS for operating and waiver services costs;
- Brokerages are designated as FMS;
- Providers aren't required to affiliate with Brokerages; may have a provider agreement directly with DHS; and
- Participants may acquire services through other means.

(b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS:
A provider who does not voluntarily agree to contract with a designated OHCDS may execute a provider agreement with DHS and, based upon the services provided, would be enrolled in a Medicaid-approved payment system.

(c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS:
Individual assistance is provided to the participant from their Support Services Brokerage as requested, including the provision of referrals to qualified providers that the participant can interview.
Oregon Administrative Rules require the provision of basic information by Support Services Brokerages to participants upon entry to Support Services including the right to choose a Support Services Brokerage within their geographic area, select among available Personal Agents, select among qualified providers, direct the services of providers and raise and resolve concerns about Brokerage services, including specific rights to notification and hearing for Medicaid recipients when services covered under Medicaid are denied, terminated, suspended, or reduced.
Participants acknowledge by signature that they may only use qualified providers and the limits of payment by the Support Services Brokerage based upon the individualized budget.

Participants may find their own candidates for employment, screen otherwise qualified candidates for ability to meet participant needs, hire, supervise, direct and discharge employees enrolled as qualified Providers. Participants establish work schedules and train employees in how they prefer to receive their services. Participants have the opportunity to exercise budget authority over their Individual Support Plan. SPD offers a basic benefit level to all participants as well as enhanced funding based on an assessment (Basic Supplement Criteria Inventory) for extraordinary care needs and particular caregiver circumstances. A comprehensive assessment (Customer Goal Survey) is completed for all participants. Within the participant's benefit level and based upon the necessary supports identified in assessments, the participant chooses what supports are desired. Within SPD rate guidelines, participants choose the rate of pay that providers receive.

(d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver:
Support Services Brokerages maintain lists of providers who have met minimum qualifications as defined by Oregon Administrative Rules including a criminal history check conducted by DHS. Participants may also select their own providers who are referred to the Support Services Brokerage for qualification. The participant has the right to fire the provider at any time, for any reason.

(e) how it is assured that OHCDS contracts with providers meet applicable requirements:
SPD conducts a review of OHCDS agreement instruments once a year.

(f) how financial accountability is assured when an OHCDS arrangement is used:
SPD monitors and assesses the performance of Support Services Brokerages and sub-contracted FMS entities in the following ways:
· Annual Field Reviews conducted by SPD staff that review a statistically valid number of participant files including all fiscal and financial records. Expenditures are reviewed for being allowed under the waiver and Oregon Administrative rule, prior authorization in the Individual Support Plan and whether expenditures are accurately and appropriately assigned and reported.
· All expenditures are reported monthly to SPD from Support Services Brokerages via the CPMS (Client Process Monitoring System). SPD staff identifies inconsistencies based on waiver and Brokerage enrollment dates and expenditures that appear anomalous and follow up with SPD staff assigned to liaison with Support Services Brokerages to see correction of errors.
· The Department of Human Resources (DHS) Audit & Consulting Services Division conducts periodic reviews of programs administered by DHS; Support Service Brokerages were audited in 2004.
· Support Services Brokerages are required by contract to monitor services provided by Fiscal Intermediaries when these services are subcontracted out. In practice, this is done monthly as billings and tax withholding are reconciled against individual plan budgets.
· Support Services Brokerages are required by contract to comply with applicable audit requirements and responsibilities of the Office of Management and Budget (OMB) Circular A-133.
· Certification reviews every two years by state staff.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a.

Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a.

Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	7569.74	5926.00	13495.74	39438.00	4795.00	44233.00	30737.26
2	7455.74	6222.00	13677.74	41410.00	5035.00	46445.00	32767.26
3	7723.52	6533.00	14256.52	43480.00	5286.00	48766.00	34509.48
4	7885.89	6860.00	14745.89	45654.00	5551.00	51205.00	36459.11
5	8048.09	7203.00	15251.09	47937.00	5828.00	53765.00	38513.91

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care: ICF/MR
Year 1	7052	7052
Year 2	7752	7752
Year 3	8452	8452
Year 4	9152	9152
Year 5	9852	9852

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

340 Days during the waiver year.
Actual LOS from most recent 372 report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

SPD based Factor D cost projections on actual expenditures incurred for delivery of waiver services to the adults served under this waiver during the most recent reporting year, inflated forward and accounting for other relevant current cost information.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SPD based Factor D' cost projections on actual expenditures incurred for delivery of acute care services to the adults served under this waiver during the most recent reporting year, inflated forward.

SPD drew the Waiver D' base data from recent 372 reports.

D' data includes prescription drug expenditures for this waiver population.
Since Medicare Part D has been in place since 2005, the current data SPD is using for Waiver D' projections automatically excludes Medicare Part D.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SPD based Factor G cost projections on actual expenditures incurred for delivery of ICF/MR services to similar adults over a one-year period.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SPD based Factor G' cost projections on actual expenditures incurred for delivery of acute care services to similar adults served in ICFs/MR over a one-year period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Homemaker	
Respite	
Supported Employment	
Occupational Therapy Services	
Physical Therapy Services	
Speech, Hearing and Language Services	
Chore Services	
Community Living and Inclusion Support	
Emergent Services	
Environmental Accessibility Adaptations	
Family Training	
Non-Medical Transportation	
Personal Emergency Response Systems	
Special Diets	
Specialized Medical Equipment and Supplies	
Specialized Supports	
Support Services Brokerage Operations (Organized Health Care Delivery System)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							17549.28
Homemaker	☐	Hours	72	14.00	17.41	**17549.28**	
Respite Total:							2433640.30
Overnight	☐	Overnight	6	19.63	196.12	**23099.01**	
Daytime	☐	Hours	602	230.26	17.39	**2410541.28**	
Supported Employment Total:							2914321.58
Supported Employment	☐	Hours	815	92.09	38.83	**2914321.58**	
Occupational Therapy Services Total:							25971.93
Occupational Therapy Services	☐	Hours	4	106.39	61.03	**25971.93**	
Physical Therapy Services Total:							3919.96
Physical Therapy Services	☐	Hours	3	21.41	61.03	**3919.96**	
Speech, Hearing and Language Services Total:							5199.76
Speech, Hearing and Language Services	☐	Hours	6	14.20	61.03	**5199.76**	
Chore Services Total:							7015.84
Chore Services	☐	Hours	54	7.51	17.30	**7015.84**	
Community Living and Inclusion Support Total:							29665425.00
Community Living and Inclusion Support	☐	Hours	1590	850.00	21.95	**29665425.00**	
Emergent Services Total:							9300720.00
Emergent Services	☐	Days	160	325.00	178.86	**9300720.00**	
Environmental Accessibility Adaptations Total:							71191.52
Environmental Accessibility Adaptations	☐	Event -one/year	58	1.00	1227.44	**71191.52**	
Family Training Total:							17782.14
Family Training	☐	Event	4	18.02	246.70	**17782.14**	
Non-Medical Transportation Total:							2407898.19
Non-Medical Transportation	☐	Rides	1146	44.16	47.58	**2407898.19**	
Personal Emergency							4954.42

GRAND TOTAL:	**53381799.47**
Total Estimated Unduplicated Participants:	**7052**
Factor D (Divide total by number of participants):	**7569.74**
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Systems Total:							
Personal Emergency Response Systems	☐	Purchase Costs	17	16.73	17.42	**4954.42**	
Special Diets Total:							5920.74
Special Diets	☐	Months	7	3.00	281.94	**5920.74**	
Specialized Medical Equipment and Supplies Total:							16911.66
Specialized Medical Equipment and Supplies	☐	Purchase Costs	74	5.83	39.20	**16911.66**	
Specialized Supports Total:							205803.00
Specialized Supports	☐	Hours	65	45.00	70.36	**205803.00**	
Support Services Brokerage Operations (Organized Health Care Delivery System) Total:							6277574.16
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐	Months	13	12.00	40240.86	**6277574.16**	

GRAND TOTAL:	**53381799.47**
Total Estimated Unduplicated Participants:	**7052**
Factor D (Divide total by number of participants):	**7569.74**
Average Length of Stay on the Waiver:	326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							19642.56
Homemaker	☐	Hours	79	14.00	17.76	**19642.56**	
Respite Total:							2731633.31
Overnight	☐	Overnight	7	19.63	200.04	**27487.50**	

GRAND TOTAL:	**57796905.83**
Total Estimated Unduplicated Participants:	**7752**
Factor D (Divide total by number of participants):	**7455.74**
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Daytime	☐	Hours	662	230.26	17.74	**2704145.81**	
Supported Employment Total:							3268325.67
Supported Employment	☐	Hours	896	92.09	39.61	**3268325.67**	
Occupational Therapy Services Total:							26491.11
Occupational Therapy Services	☐	Hours	4	106.39	62.25	**26491.11**	
Physical Therapy Services Total:							3998.32
Physical Therapy Services	☐	Hours	3	21.41	62.25	**3998.32**	
Speech, Hearing and Language Services Total:							6187.65
Speech, Hearing and Language Services	☐	Hours	7	14.20	62.25	**6187.65**	
Chore Services Total:							7820.54
Chore Services	☐	Hours	59	7.51	17.65	**7820.54**	
Community Living and Inclusion Support Total:							33267062.00
Community Living and Inclusion Support	☐	Hours	1748	850.00	22.39	**33267062.00**	
Emergent Services Total:							10435568.00
Emergent Services	☐	Days	176	325.00	182.44	**10435568.00**	
Environmental Accessibility Adaptations Total:							80127.36
Environmental Accessibility Adaptations	☐	Event - one/year	64	1.00	1251.99	**80127.36**	
Family Training Total:							18137.49
Family Training	☐	Event	4	18.02	251.63	**18137.49**	
Non-Medical Transportation Total:							2700286.85
Non-Medical Transportation	☐	Rides	1260	44.16	48.53	**2700286.85**	
Personal Emergency Response Systems Total:							5648.55
Personal Emergency Response Systems	☐	Purchase Costs	19	16.73	17.77	**5648.55**	
Special Diets Total:							6901.92

GRAND TOTAL:	**57796905.83**
Total Estimated Unduplicated Participants:	**7752**
Factor D (Divide total by number of participants):	**7455.74**
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Special Diets	☐	Months	8	3.00	287.58	**6901.92**	
Specialized Medical Equipment and Supplies Total:							18879.76
Specialized Medical Equipment and Supplies	☐	Purchase Costs	81	5.83	39.98	**18879.76**	
Specialized Supports Total:							229305.15
Specialized Supports	☐	Hours	71	45.00	71.77	**229305.15**	
Support Services Brokerage Operations (Organized Health Care Delivery System) Total:							4970889.60
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐	Months	7640	12.00	54.22	**4970889.60**	
					GRAND TOTAL:		**57796905.83**
					Total Estimated Unduplicated Participants:		**7752**
					Factor D (Divide total by number of participants):		**7455.74**
					Average Length of Stay on the Waiver:		326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							21816.48
Homemaker	☐	Hours	86	14.00	18.12	**21816.48**	
Respite Total:							3039463.70
Overnight	☐	Overnight	8	19.63	204.04	**32042.44**	
Daytime	☐	Hours	722	230.26	18.09	**3007421.25**	
Supported Employment Total:							3634865.97
Supported Employment	☐	Hours	977	92.09	40.40	**3634865.97**	
					GRAND TOTAL:		**65279166.67**
					Total Estimated Unduplicated Participants:		**8452**
					Factor D (Divide total by number of participants):		**7723.52**
					Average Length of Stay on the Waiver:		326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Services Total:							27023.06
Occupational Therapy Services	☐	Hours	4	106.39	63.50	**27023.06**	
Physical Therapy Services Total:							4078.60
Physical Therapy Services	☐	Hours	3	21.41	63.50	**4078.60**	
Speech, Hearing and Language Services Total:							7213.60
Speech, Hearing and Language Services	☐	Hours	8	14.20	63.50	**7213.60**	
Chore Services Total:							8651.52
Chore Services	☐	Hours	64	7.51	18.00	**8651.52**	
Community Living and Inclusion Support Total:							37003084.00
Community Living and Inclusion Support	☐	Hours	1906	850.00	22.84	**37003084.00**	
Emergent Services Total:							11612016.00
Emergent Services	☐	Days	192	325.00	186.09	**11612016.00**	
Environmental Accessibility Adaptations Total:							89392.10
Environmental Accessibility Adaptations	☐	Event - one/year	70	1.00	1277.03	**89392.10**	
Family Training Total:							18500.05
Family Training	☐	Event	4	18.02	256.66	**18500.05**	
Non-Medical Transportation Total:							3003454.08
Non-Medical Transportation	☐	Rides	1374	44.16	49.50	**3003454.08**	
Personal Emergency Response Systems Total:							6369.61
Personal Emergency Response Systems	☐	Purchase Costs	21	16.73	18.13	**6369.61**	
Special Diets Total:							7919.91
Special Diets	☐	Months	9	3.00	293.33	**7919.91**	
Specialized Medical Equipment and Supplies Total:							20921.77
Specialized Medical Equipment and Supplies	☐	Purchase Costs	88	5.83	40.78	**20921.77**	

GRAND TOTAL:	**65279166.67**
Total Estimated Unduplicated Participants:	**8452**
Factor D (Divide total by number of participants):	**7723.52**
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Supports Total:							253672.65
Specialized Supports	☐	Hours	77	45.00	73.21	**253672.65**	
Support Services Brokerage Operations (Organized Health Care Delivery System) Total:							6520723.56
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐	Months	8073	12.00	67.31	**6520723.56**	
					GRAND TOTAL:		**6527916.67**
					Total Estimated Unduplicated Participants:		**8452**
					Factor D (Divide total by number of participants):		**7723.52**
					Average Length of Stay on the Waiver:		326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							24060.96
Homemaker	☐	Hours	93	14.00	18.48	**24060.96**	
Respite Total:							3358936.81
Overnight	☐	Overnight	9	19.63	208.12	**36768.56**	
Daytime	☐	Hours	782	230.26	18.45	**3322168.25**	
Supported Employment Total:							4015140.58
Supported Employment	☐	Hours	1058	92.09	41.21	**4015140.58**	
Occupational Therapy Services Total:							27563.52
Occupational Therapy Services	☐	Hours	4	106.39	64.77	**27563.52**	
Physical Therapy Services Total:							4160.18
Physical Therapy Services	☐	Hours	3	21.41	64.77	**4160.18**	
					GRAND TOTAL:		**72171696.08**
					Total Estimated Unduplicated Participants:		**9152**
					Factor D (Divide total by number of participants):		**7885.89**
					Average Length of Stay on the Waiver:		326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Hearing and Language Services Total:							8277.61
Speech, Hearing and Language Services	☐	Hours	9	14.20	64.77	**8277.61**	
Chore Services Total:							9513.97
Chore Services	☐	Hours	69	7.51	18.36	**9513.97**	
Community Living and Inclusion Support Total:							40877520.00
Community Living and Inclusion Support	☐	Hours	2064	850.00	23.30	**40877520.00**	
Emergent Services Total:							12831156.00
Emergent Services	☐	Days	208	325.00	189.81	**12831156.00**	
Environmental Accessibility Adaptations Total:							98995.32
Environmental Accessibility Adaptations	☐	Event - one/year	76	1.00	1302.57	**98995.32**	
Family Training Total:							18869.82
Family Training	☐	Event	4	18.02	261.79	**18869.82**	
Non-Medical Transportation Total:							3317701.94
Non-Medical Transportation	☐	Rides	1488	44.16	50.49	**3317701.94**	
Personal Emergency Response Systems Total:							7114.77
Personal Emergency Response Systems	☐	Purchase Costs	23	16.73	18.49	**7114.77**	
Special Diets Total:							8976.00
Special Diets	☐	Months	10	3.00	299.20	**8976.00**	
Specialized Medical Equipment and Supplies Total:							23040.16
Specialized Medical Equipment and Supplies	☐	Purchase Costs	95	5.83	41.60	**23040.16**	
Specialized Supports Total:							278892.45
Specialized Supports	☐	Hours	83	45.00	74.67	**278892.45**	
Support Services Brokerage Operations (Organized Health							7261776.00

GRAND TOTAL:	**72171696.08**
Total Estimated Unduplicated Participants:	**9152**
Factor D (Divide total by number of participants):	**7885.89**
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Delivery System) Total:							
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐	Months	8440	12.00	71.70	**7261776.00**	
					GRAND TOTAL:		**72171696.08**
					Total Estimated Unduplicated Participants:		**9152**
					Factor D (Divide total by number of participants):		**7885.89**
					Average Length of Stay on the Waiver:		326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							26390.00
Homemaker	☐	Hours	100	14.00	18.85	**26390.00**	
Respite Total:							3690471.84
Overnight	☐	Overnight	10	19.63	212.28	**41670.56**	
Daytime	☐	Hours	842	230.26	18.82	**3648801.27**	
Supported Employment Total:							4408548.14
Supported Employment	☐	Hours	1139	92.09	42.03	**4408548.14**	
Occupational Therapy Services Total:							28116.75
Occupational Therapy Services	☐	Hours	4	106.39	66.07	**28116.75**	
Physical Therapy Services Total:							4243.68
Physical Therapy Services	☐	Hours	3	21.41	66.07	**4243.68**	
Speech, Hearing and Language Services Total:							9381.94
Speech, Hearing and Language Services	☐	Hours	10	14.20	66.07	**9381.94**	
					GRAND TOTAL:		**79289776.95**
					Total Estimated Unduplicated Participants:		**9852**
					Factor D (Divide total by number of participants):		**8048.09**
					Average Length of Stay on the Waiver:		326

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Services Total:							10409.01
Chore Services	☐	Hours	74	7.51	18.73	**10409.01**	
Community Living and Inclusion Support Total:							44894399.00
Community Living and Inclusion Support	☐	Hours	2222	850.00	23.77	**44894399.00**	
Emergent Services Total:							14094808.00
Emergent Services	☐	Days	224	325.00	193.61	**14094808.00**	
Environmental Accessibility Adaptations Total:							108946.84
Environmental Accessibility Adaptations	☐	Event - one/year	82	1.00	1328.62	**108946.84**	
Family Training Total:							19247.52
Family Training	☐	Event	4	18.02	267.03	**19247.52**	
Non-Medical Transportation Total:							3643332.48
Non-Medical Transportation	☐	Rides	1602	44.16	51.50	**3643332.48**	
Personal Emergency Response Systems Total:							7888.20
Personal Emergency Response Systems	☐	Purchase Costs	25	16.73	18.86	**7888.20**	
Special Diets Total:							10070.94
Special Diets	☐	Months	11	3.00	305.18	**10070.94**	
Specialized Medical Equipment and Supplies Total:							25231.42
Specialized Medical Equipment and Supplies	☐	Purchase Costs	102	5.83	42.43	**25231.42**	
Specialized Supports Total:							305020.80
Specialized Supports	☐	Hours	89	45.00	76.16	**305020.80**	
Support Services Brokerage Operations (Organized Health Care Delivery System) Total:							8003270.40
Support Services Brokerage Operations (Organized Health Care Delivery System)	☐	Months	8945	12.00	74.56	**8003270.40**	

GRAND TOTAL:	**79289776.95**
Total Estimated Unduplicated Participants:	**9852**
Factor D (Divide total by number of participants):	**8048.09**
Average Length of Stay on the Waiver:	326